NORTH ROYALTON
pediatric dentistry

happy smiles for every child

Amberlee D. Taylor, DMD

Child's Name:_____ **Age:** _____

Please evaluate for:

- ❍ Dental caries/cavities
- ❍ Space maintenance concerns
- ❍ Sedation/general anesthesia
- ❍ Trauma/emergency
- ❍ Mouth guard

Remarks: _____

Radiographs:

- ❍ Parents will bring
- ❍ Please take if needed
- ❍ Will be mailed
- ❍ Will send electronically

Referring Doctor: _____

Phone: _____

Appointment: _____ (Day) _____ (Date) _____ (Time)

Tel: 440.457.1222 • NorthRoyaltonPediatricDentistry.com
6391 Royalton Road, Suite B • North Royalton, OH 44133