

James Collette, DDS • David Hamilton, DDS • Kirk Morris, DDS



DATE: _____

INTRODUCING: _____

DOB: _____

PATIENT PHONE: _____

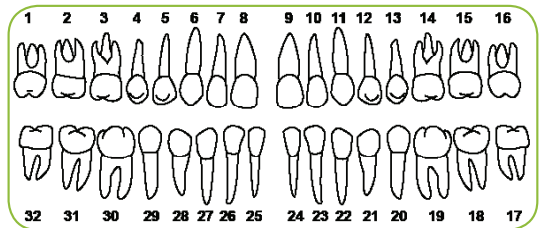
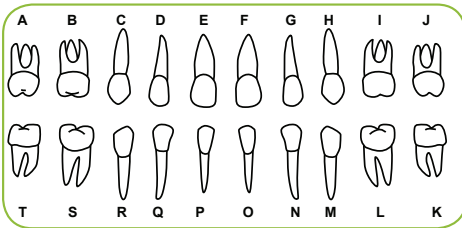
Please evaluate for:

Dental Caries/Cavities

Sedation/General Anesthesia

CO2 Laser/Frenectomy

Trauma/Emergency



Radiographs:

No radiographs taken

Will send electronically to: info@smilesurfers.com

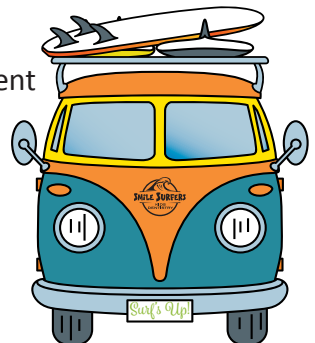
Remarks: _____

Please accept patient into your practice

Please have patient return to our practice
for regular recall after completion of treatment

Referred By: Dentist: _____

Office: _____

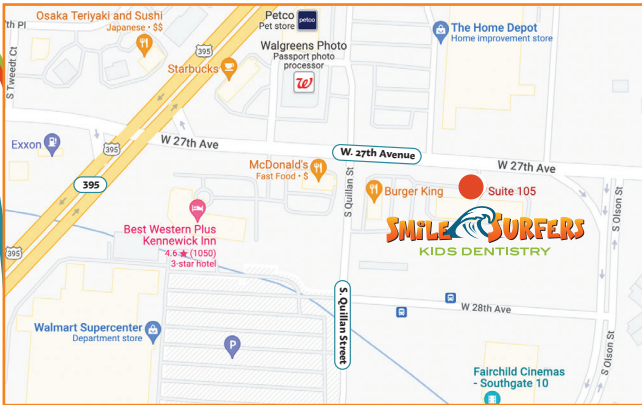


Smile Surfers Kids Dentistry

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