



Michael Rees, DMD

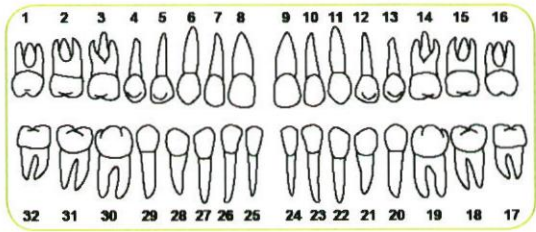
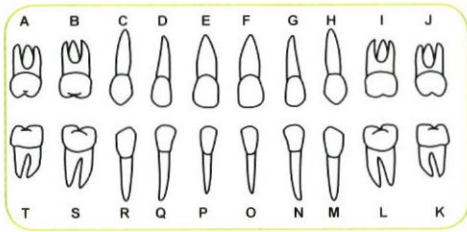
DATE: _____ INTRODUCING: _____

DOB: _____ PATIENT PHONE: _____

Please evaluate for:

- Dental Caries/Cavities
- CO2 Laser/Frenectomy

- Sedation/General Anesthesia
- Trauma/Emergency



Radiographs:

- No radiographs taken
- Will send electronically to: infoml@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

**1429 S. Pioneer Way, Suite 2
Moses Lake, WA 98837
P. (509) 431-6003 F. (509) 431-6004**



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