



DATE: \_\_\_\_\_

INTRODUCING: \_\_\_\_\_

DOB: \_\_\_\_\_

PATIENT PHONE: \_\_\_\_\_

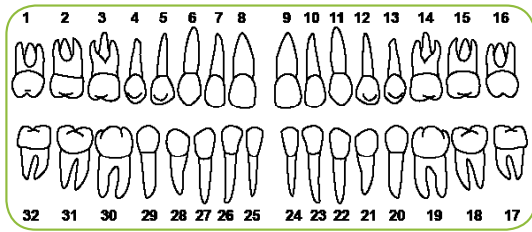
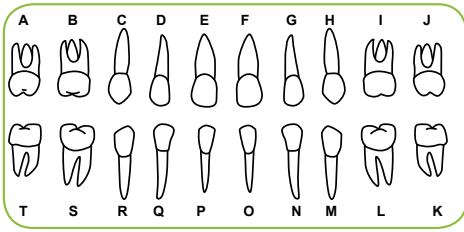
**Please evaluate for:**

Dental Caries/Cavities

Sedation/General Anesthesia

CO2 Laser/Frenectomy

Trauma/Emergency



**Radiographs:**

No radiographs taken

Will send electronically to: [info@smilesurfers.com](mailto:info@smilesurfers.com)

**Remarks:** \_\_\_\_\_

\_\_\_\_\_

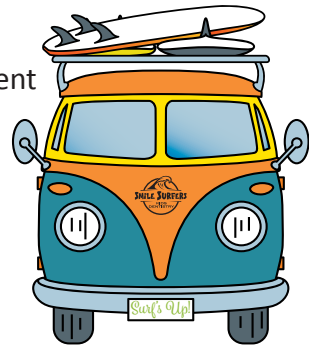
\_\_\_\_\_

Please accept patient into your practice

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

**Referred By: Dentist:** \_\_\_\_\_

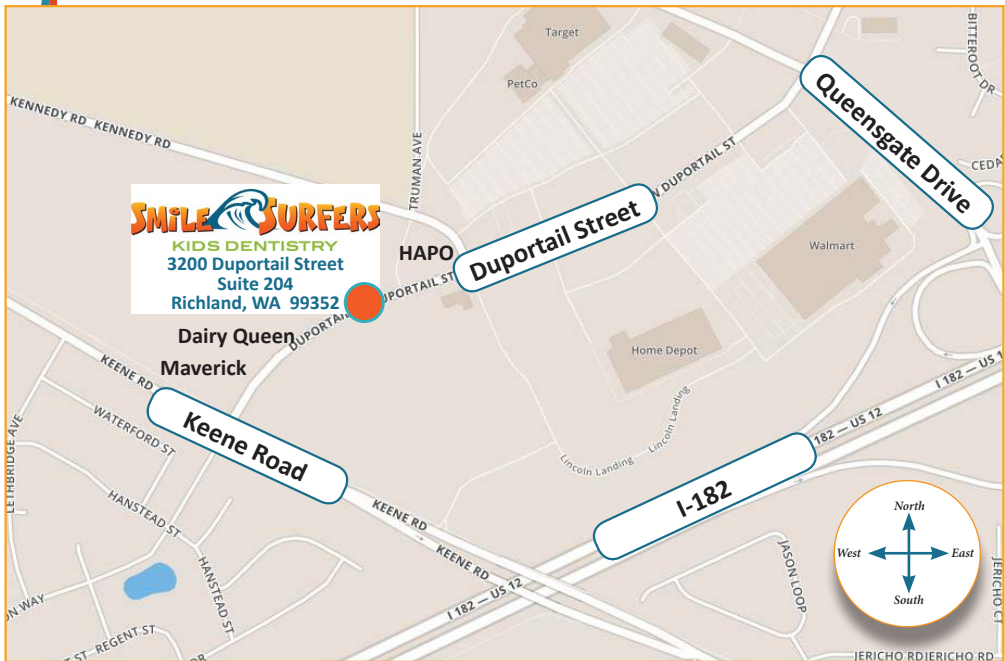
**Office:** \_\_\_\_\_



# Smile Surfers Kids Dentistry

**3200 Duportail Street, Suite 204**  
**Richland WA 99352**  
**(509) 946-9999 Fax: (509) 946-6492**

Please complete new patient paperwork  
available online: [www.Richland.SmileSurfers.com](http://www.Richland.SmileSurfers.com).



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