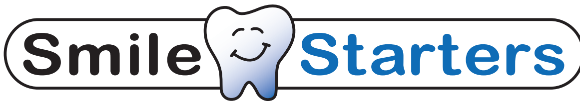

General Dentistry for Youth

first tooth through age 20

Dental Referral Form

Referring Doctor ______________________________

Patient Name ______________________________

Age ____________________

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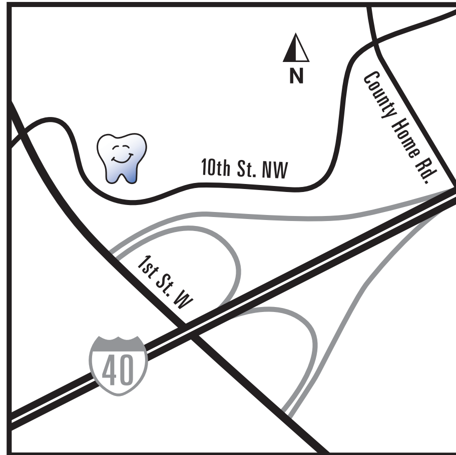

Please call this office.

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