**Carlos Dorantes, DDS. MS.**
6201 Summitview Ave Suite 100
Yakima, WA. 98908
(509)966-4433 - Fax (509)966-1021

Summitview Pediatric Dentistry

Today's Date: _____

Referring Dentist's Name/office _____

Referring Dentist's Phone _____

Patient's Name _____ Date of Birth _____

Date last seen at your office/reason _____

Parent's Name _____

Contact Phone/s _____

**Attempts to treat patient:** With no Sedation □1 □2 □3

□ None With Sedation □1 □2 □3

**Radiographs:** □ Unable to obtain □ Sent with Patient □ Mailed

□ Please accept this Patient into your practice.

□ Please complete recommended treatment and return patient to my practice.

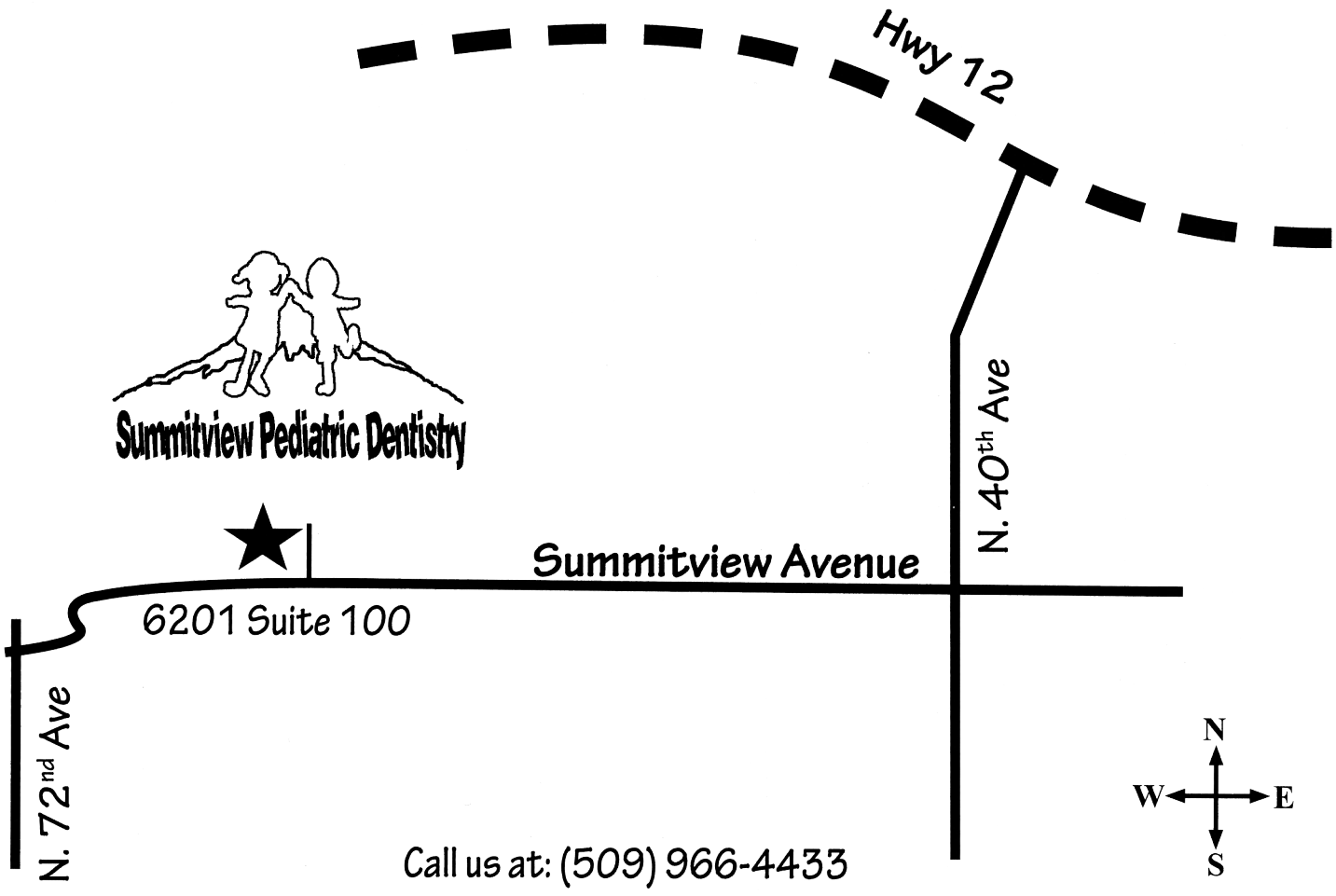
Recommended treatment and other comments: _____

_____

**If your patient requires immediate attention, please fax this referral to our office and we will contact the family within 24 hours.**

## Patient Instructions

1. Please contact our office by phone to obtain/confirm an appointment.
2. Minors must be accompanied by at least one parent or a legal guardian.
3. To expedite your registration, please feel free to download our new patient forms from our website : **www.kidentist.com**
4. Please bring any applicable insurance forms, your SSN, policy numbers and insurance identification numbers.
5. You are being referred as a NEW patient to our practice and we have assigned your child a special block of time for this. If for any reason you cannot keep this appointment, please call our office at least 48 hours ahead of time. Thank you!


Hwy 12
Summitview Pediatric Dentistry
N. 40th Ave
Summitview Avenue
6201 Suite 100
N. 72nd Ave
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Call us at: (509) 966-4433