



Check which provider you are referring to

- Christopher Lugo** DMD
- Jenny-Lee Kramar** BDS
- Stephen Sadler** DDS
- Kendra Farmer** DDS
- Stephanie Yang** DDS

Referring Doctor _____ Date _____

Patient's Name _____ Gender M F

Parent's Name _____

Phone (Home) _____ (Cell) _____

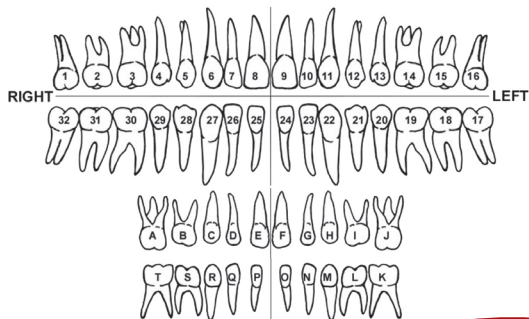
New Patient Restorative Care

Consultation/Second Opinion Extraction (Mark on Chart)

X-Rays Taken Yes No Date _____

Mailed Emailed (see back for office emails)

Patient to Hand Carry to Appointment



- | | | | |
|---|---|---|--|
| Marysville
919 State Ave. #104
Marysville, WA 98270
Office: (360) 659-8100
Fax: (360) 659-8133 | Monroe
14090 Fryelands Blvd SE. #348
Monroe, WA 98272
Office: (360) 863-8700
Fax: (360) 822-7184 | Lake Stevens
9421 N. Davies Rd. #A
Lake Stevens, WA 98258
Office: (425) 367-4149
Fax: (425) 609-4530 | Stanwood
7104 265th Street NW. #110
Stanwood, WA 98292
Office: (360) 339-8000
Fax: (360) 339-8044 |
|---|---|---|--|

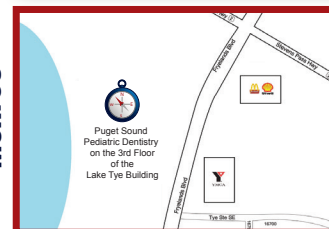
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team@pugetsoundmv.com

Marysville



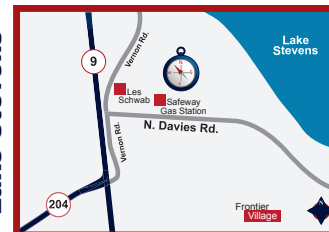
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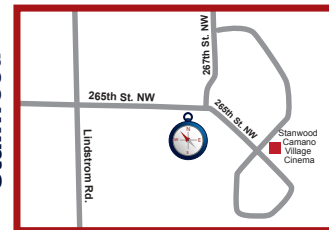
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Stanwood



PROJECT INFORMATION

CLIENT: PUGET SOUND PEDIATRIC DENTISTRY		SIZE: 8.5" X 5.5"
PROJECT: REFERRAL PAD		QUANTITY: 10
DIRECTION: PROOF 3	PAGE: 01 of 01	DATE: 05/05/2017

PRE-FLIGHT ERRORS

- RESOLUTION TOO LOW
- TYPE NOT OUTLINED
- INADEQUATE BLEED
- LINKS NOT EMBEDDED
- DIMENSIONS INCORRECT
- COLOR/MODE ISSUE

PRODUCTION NOTES

SETUP BY:	FILE SCALE:	PRINT RES:
NOTES:		



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