



**Michael Suh, DDS**  
Board Certified Pediatric Dentist

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**Date:** \_\_\_\_\_

**Introducing:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Reason for Referral:**

- 1<sup>st</sup> Dental Visit
- Special Medical Consideration
- Toothache
- Dental Decay
- Trauma
- Sedation/Anesthesia



Scan here to  
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appointment

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**X-rays Enclosed:** Yes No Emailed

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

**Referral Phone #:** \_\_\_\_\_

**Patient Phone #:** \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17