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Intro	ducir	ng:					Age:										
Refe	erring	Pract	ice: _														
Date	e of Lo	ast Ex	am: _					Do	ate of	Last	Prop	hy:_					
Date of Last Fluoride Treatment:										Date of Last X-rays: X-ray Delivery							
R	1	2	3	a 4	b 5	C 6	d 7	e 8	f 9	g 10	h 11	i 12	j 13	14	15	16	L
_	32	31	30	29					24					19	18	17	_
We are referring the patient above for the following reasons:															s:		
																2)
	R	eferr	ing D	octo	r's No	ame		DDWA	Compass	GĄ.		_, _	1ST AVI		COLORADO I		
		P	hone	Num	nber					GARFIELD ST		ACKSON ST		HARRISON ST	BLVD		
		ou f					3650	E. 1s	Ave	., Ste	. 301	• Der	nver,	CO 8	30206		