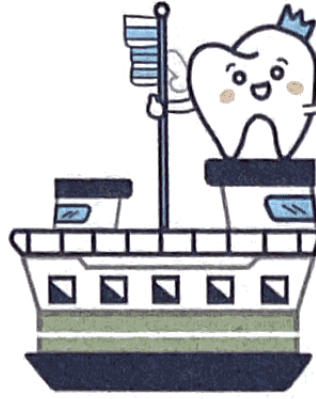


THE TOOTH FERRY

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2019

🌊 PEDIATRIC DENTISTRY 🌊

Megan K. Posthuma, DDS

*CREATING POSITIVE ASSOCIATIONS WITH DENTAL
CARE THAT LAST A LIFETIME*

Patient's name: _____

Patient DOB: ___/___/___

Parent's name: _____

Parent's phone number: _____

Reason for referral:

- Initial/First visit**
- Operative dental treatment:**

- Complex medical history:**

- Other:** _____

THANK YOU FOR YOUR KIND REFERRAL! WE APPRECIATE YOUR
TRUST IN ALLOWING US TO BE PART OF YOUR PATIENT'S DENTAL
TREATMENT TEAM!

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