



**PEDIATRIC & ADOLESCENT
DENTISTRY**

REFERRAL TO
SAUL OVALLE, DDS, MS
KRISTIN BOTHUN, DDS
STEPHEN SOLIE, DDS
EMILY STARMAN, DDS

Introducing _____

Patient's Phone # _____

Patient's Date of Birth _____

Referred by Dr. _____

Date of Last Ex, Pro, FL _____

Date of Last BW's/Opan/PA _____

Reason for Referral _____

Please Email Digital X-Rays to:

MANKATO OFFICE
mankato@kidswillsmile.com

NEW ULM OFFICE
newulm@kidswillsmile.com

APPOINTMENT

Date _____ Time _____

(If unable to keep this appointment, please give 24 hours notice)

SPECIALIZED CARE FOR YOUR CHILD AND TEENAGER
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MANKATO OFFICE
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