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Paul T. Fallon D.D.S.

Kipp Slocum D.D.S.

PATIENT REFERRAL FORM – TRAUMA / OTHER

Introducing: _____

Appointment: _____

Referred by: _____

X-Ray Sent: With Patient By Mail

Remarks:

Directions:

By Email:

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By Fax:

1.315.453.0150

By Mail:

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