canyon kids dental

PATIENT NAME _____

PATIENT DOB _____

PARENT/GUARDIAN NAME _____

PARENT/GUARDIAN PHONE # _____

DATE _____ **REFERRED BY** _____

Reason for Referral:

3326 4th Street Suite 4
Lewiston, Idaho 83501
phone: (208) 743-2505
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hello@canyonkidsdental.com