



# Dina Lunken D.D.S., P.C.

Dentistry for Children and Adolescents

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Date: \_\_\_\_\_

Referring Office/Dr: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Most Recent Prophyl: \_\_\_\_\_

- Exam
- X-rays
- Cleaning
- Fluoride

Most Recent Visit: \_\_\_\_\_

Treatment Diagnosed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please send any x-rays and all the information to [dinalunkendds@gmail.com](mailto:dinalunkendds@gmail.com) or fax (815) 223-4355

