



ISLAND VIEW
DENTAL

HEIDI JOHNSON, DDS



REFERRING INFORMATION

REFERRING DOCTOR _____

PHONE _____ FAX _____

ADDRESS _____ CITY _____ ZIP _____

EMAIL _____



PATIENT INFORMATION

PATIENT NAME _____

DATE OF BIRTH _____

PHONE _____

EMAIL _____



REASON FOR REFERRAL / PATIENT CONCERNS



RELEVANT HISTORY, SLEEP STUDY, OR PRIOR TREATMENT (IF AVAILABLE)



RECORDS INCLUDED (IF AVAILABLE)

☐ Sleep study

☐ Recent dental records

☐ Imaging

☐ Other



OUTSTANDING DENTAL WORK OR TREATMENT CONCERNS



Fax: 1-855-264-3656



Phone: 425-918-5812



office@islandviewdental.com



700 3rd Street - Suite A
Mukiteo, WA 98275