Orthodontic Referral

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(210) 922-3483
www.SSCDC.org

Date: _____

Referring Doctor/Practice:

_____

We are referring our patient: _____for an orthodontic evaluation.

Patient Contact:

Home/Cell Phone: _____
E-mail address: _____

Please evaluate for:

☐ Early Tx ☐ Full/Adult Treatment
☐ Other: _____

Remarks:_____
_____
_____
_____

Patient is current with Cleanings & Restorative is:

- ☐ Completed
- ☐ Needed prior to orthodontic treatment
- ☐ Needed after orthodontic treatment

Please ask to speak with one of our Orthodontic Coordinators.

Thank you!

(210) 922-3483 Fax: (210) 598-5262

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