Align Orthodontics

PATIENT REFERRAL

Dear Barbara,

I am referring _____

Address _____

_____

Telephone _____ DOB _____

For:

- ☐ Consultation Only
- ☐ Consultation and treatment
- ☐ Second Opinion

Please Note:

- ☐ Patient is dentally fit for orthodontic treatment

Radiographs enclosed:

- ☐ None
- ☐ OPG
- ☐ Lat Ceph
- ☐ Other

Comments

Referring Practitioner _____

Address _____

Telephone _____ Date _____

PLEASE NOTE:
On future visits any changes to the above should be advised.

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