2125 Green Vista Drive, Suite 104
Sparks, Nevada, 89431
(775) 674-1444 • www.andrewsbraces.com

ORTHODONTIC REFERRAL

Introducing: ______________________ Date: __________

Referring Dr.: ______________________ DOB: __________

For evaluation of the following:

- ❑ Crowding / Spacing: ______________________
- ❑ Crossbite(s): ______________________
- ❑ Open Bite: ______________________
- ❑ Overbite / Underbite: ______________________
- ❑ Overjet: ______________________
- ❑ Space Maintenance: ______________________
- ❑ Other: ______________________

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Comments: ______________________

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Patient's Address: ______________________

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Patient's Phone number: ______________________

Thank you for your confidence in referring to our office. We will send you a "Diagnostic Evaluation" as soon as possible after seeing your patient.

1 - Patient's copy   2 - Dr. Andrews' copy   3 - Referring Dr's copy