Smiles on Yonge ORTHODONTICS

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Certified Specialist in Orthodontics

REFERRAL FORM

Doctor: _____ **Date:** _____

Patient: _____ **Age:** _____ **Phone:** _____

Reason for Referral:

❑ GENERAL ASSESSMENT

❑ SPECIFIC ASSESSMENT: ❑ Esthetic ❑ Function ❑ Surgical

❑ Pre-prosthodontic ❑ Periodontal ❑ Attrition

❑ T.M.D. ❑ Sleep Apnea

❑ Other:

Specific Restorative Plan: _____

_____

_____

Comments: _____

_____

_____

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