STARS ORTHODONTICS

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DATE _____ BIRTHDATE _____

PATIENT NAME _____

ADDRESS _____

CITY & PROVINCE _____ POSTAL CODE _____

TEL (CELL) _____ TEL (ALTERNATE) _____

EMAIL _____

REASON FOR REFERRAL

☐ ORTHODONTIC CONSULTATION ☐ SPECIFIC EXAMINATION REGARDING

ADDITIONAL NOTES _____

RADIOGRAPHS

☐ EMAILED ☐ NONE AVAILABLE ☐ WITH PATIENT

REFERRED BY DR. _____

TEL & ADDRESS _____

☐ PLEASE SEND MORE REFERRAL FORMS