SPAIN ORTHODONTICS

PATIENT REFERRAL

Patient Name _____ Date _____

Date of Birth _____

Parent (if applicable) _____ Referred by Dr. _____

O Please call to schedule O Please email to schedule

Phone number _____ Email _____

AREAS OF CONCERN

O Crowding O Spacing O Overbite O Underbite O TMJ

O Crossbite O Impaction O Space Maintenance O Pre-prosthetic

O Other _____

RESTORATIVE TREATMENT STATUS

O Up To Date O Treatment Pending O Interdisciplinary (Collaborative Planning)

RADIOGRAPHS AVAILABLE O Pano O BW/PA's O Other _____

COMMENTS

_____

_____

19929 Ballinger Way NE Ste 201
Shoreline WA 98155
206.693.3123 Phone
206.453.3994 Fax
braceyourself@spainortho.com

www.spainortho.com
Online Scheduling Available

PLATINUM+
INVISALIGN
PROVIDER

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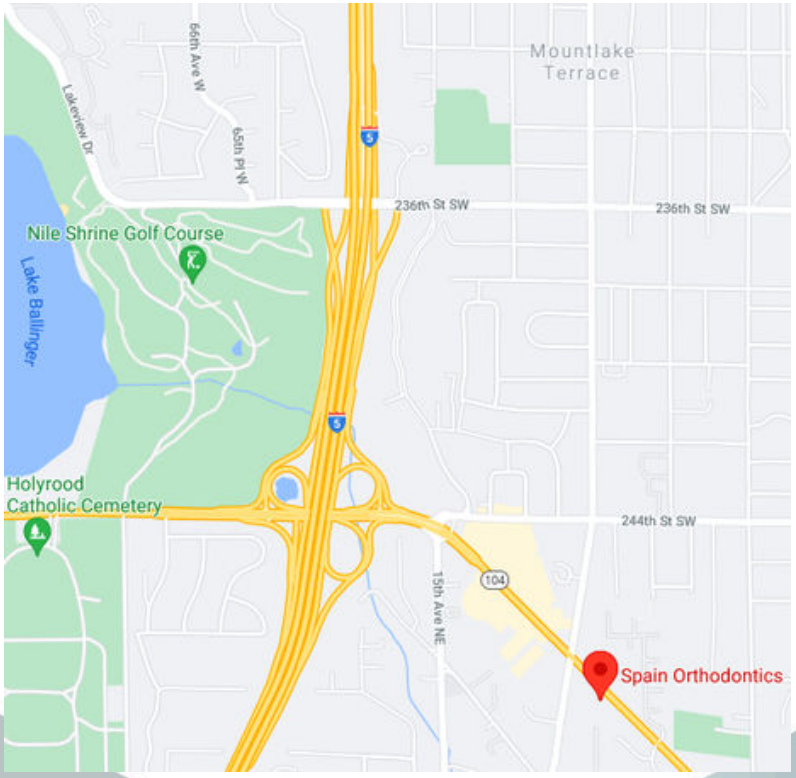
Shoreline WA 98155
206.693.3123 Phone
206.453.3994 Fax

Schedule Online at
www.spainortho.com
braceyourself@spainortho.com

I-5 Exit 177 East
towards Lake Forest Park



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WWW.SPAINORTHO.COM