VICTORIA LYNSKEY
Orthodontist

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Patient Referral

Referring Dentist ______________________________ Date ______________

Patient Name ______________________________ Gender ☐ M ☐ F ☐ Other

Phone ______________________________ DOB ______________

Parent/Guardian Name ______________________________

Referral Details

Reason for Referral

Select treatment needed:

- ☐ Crowding/Spacing
- ☐ Impacted/Missing Teeth #
- ☐ Early Orthodontic Assessment
- ☐ Restorative/Prosthetic Concerns
- ☐ Excessive Overbite/Overjet
- ☐ Crossbite
- ☐ Invisalign
- ☐ Other: ______________________________

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Restorative Work Is:

- ☐ Completed
- ☐ Required Post-Orthodontic Treatment
- ☐ Pending

Appointment Details

Please contact patient directly at ______________________________

Comments ______________________________

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Brace Yourself for a Stunning Smile!

Submit Form Via: Fax (707) 525-1554 | **Email** office@stunningsmile.com