

PATIENT NAME: _____ DATE: _____

GUARDIAN NAME: _____

PHONE: _____ EMAIL: _____

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

- ORTHODONTIC EVALUATION
- EARLY INTERCEPTIVE TREATMENT
- CROWDING/SPACING
- CROSSBITE / OVERJET / OVERBITE / UNDERBITE
- INVISALIGN / CLEAR BRACES
- RETAINERS
- ORTHOGNATHIC SURGERY EVALUATION
- OTHER _____

REMARKS FROM DENTIST:

- PLEASE CALL ME PRIOR TO STARTING TREATMENT
- PERIODONTAL CHARTING AVAILABLE
- PANORAMIC RADIOGRAPH NEEDED
- CURRENT PANORAMIC RADIOGRAPH AVAILABLE

REFERRING DR.: _____ PHONE: _____

REMARKS: _____

REFERRING OFFICE:

PLEASE EMAIL OR FAX A COPY OF THIS FORM TO OUR OFFICE AND SEND THE ORIGINAL WITH YOUR PATIENT.
THANK YOU FOR YOUR KIND REFERRALS.

Phone: 503-643-2614 Fax: 503-643-9345 Email: INFO@DO-SMILES.COM

INSTRUCTIONS FOR THE PATIENT OR PARENT:

- > Call our office at 503-643-2614 to schedule a complimentary consultation.
- > If applicable, have your dental insurance card when you call our office so that we may help you with your benefits if treatment is recommended.
- > Prior to your initial consultation, please visit our website at: WWW.DO-SMILES/CONTACT-US to complete our new patient forms.
- > Patients under the age of 18 must be accompanied by a parent or legal guardian.

WE LOOK FORWARD TO MEETING YOU!

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.



SCAN THIS QR CODE
for more information about our office and to schedule your
complimentary initial consultation.

JOHN DELPLANCHE DMD, MS

SPECIALIZING IN BRACES & INVISALIGN
FOR CHILDREN, TEENS + ADULTS

Phone: 503-643-2614 Fax: 503-643-9345

E-Mail: INFO@DO-SMILES.COM

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