DELPLANCHE ORTHODONTICS

JOHN DELPLANCHE DMD, MS — SPECIALIZING IN BRACES & INVISALIGN FOR CHILDREN, TEENS + ADULTS

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: ______________________________

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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 exam.

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