SMILE HERO ORTHODONTICS

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☐ Child ☐ Adult

Introducing: _____

Patient Phone: _____

Reason for Referral:

☐ Early/Interceptive Treatment Evaluation

☐ Comprehensive Treatment Evaluation

☐ Orthodontic Surgical Treatment Evaluation

☐ Clear Aligner Treatment Evaluation

☐ Habit Correction

☐ Please call me before proceeding with Treatment

Last cleaning date: _____

Cavity cleared? Y / N (circle one)

Remarks: _____

_____

_____

_____

Please send current panoramic if available.

Referred by Dr: _____ Date: _____

Referred by Staff Member: _____ Date: _____

Please fax to (925) 756-2852 or email to smileheroortho@gmail.com