JANICE C. TAM, DDS, MSD
ORTHODONTIC CENTER OF SAN FRANCISCO
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ORTHODONTIC REFERRAL

Introducing_____ Phone_____

Referring Doctor_____ Date_____

Reason for Referral:

- ☐ Complete Orthodontic Evaluation
- ☐ Early Interceptive Treatment
- ☐ Limited Treatment of a specific Area_____
- ☐ TMJ_____
- ☐ Other_____

Recent Full Mouth Radiographs:

- ☐ Unavailable, please take new radiographs
- ☐ Accompanying patient
- ☐ Mailed to your office

Restorative/Periodontal Treatment Planned:

_____

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Comments:

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PATIENT COPY: Please bring this referral slip and insurance forms with you