ALGONQUIN

ORTHODONTICS

DR. MARC YARASCAVITCH

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ORTHODONTIC REFERRAL

Date ____________________

DR. MARC YARASCAVITCH • *BSc, DDS* • Practice Limited to Orthodontics

Patient's Name ____________________

Parent / Responsible Party Name ____________________

Patient's Birth Date ____________________

Patient's Address ____________________

Home Phone ____________________ Alternate Phone ____________________

E-mail ____________________

Please contact patient ❑ Patient will contact your office ❑

Appointment made on ____________________

PLEASE EVALUATE FOR:

- ❑ Early or interceptive treatment
- ❑ Comprehensive orthodontic treatment
- ❑ Surgical orthodontic treatment
- ❑ Other______________________________
- ❑ Growth modification
- ❑ Impacted or missing teeth
- ❑ Pre-prosthetic orthodontics
- ❑ Invisalign®

Referred by ____________________

Remarks ____________________

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X-RAYS PROVIDED:

- ❑ Panoramic
- ❑ Bitewings
- ❑ Periapicals
- ❑ Occlusals
- ❑ Mailed
- ❑ E-mailed (smile@algonquinortho.ca)
- ❑ Given to patient
- ❑ None current, please take