EVERGREEN ORTHODONTICS

Dr. Gaeun "Ga" Lee

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INTRODUCING: Date: _____

Patient Name: _____

Date of Birth: _____ Phone: _____

FOR A COMPLIMENTARY CONSULTATION

Referred by Dr. _____

Phone: _____

REASON FOR REFERRAL:

____ **Crowded Teeth** ____ **Spaced Teeth**

____ **Anterior Crossbite** ____ **Pasterior Crossbite**

____ **Open Bite** ____ **Deep Bite**

____ **Protruded Teeth** ____ **TMJ Dystunction**

____ **Invisalign**

____ **Tooth Alignment for Crown/Bridge/Implant(s)**

RADIOGRAPHS:

____ **Enclosed** ____ **With Patient**

____ **Emailed** ____ **Take New Radiographs**

SPECIAL NOTES: _____

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Coquitlam Office:
120 - 1960 Como Lake Ave.
Coquitlam V3J 3R3

Vancouver Office:
1310 - 750 West Broadway
Vancouver V5Z 1K1

Please email this referral to *smile@evergreenortho.ca*
& give a copy to the patient.

Please send more referral forms