T.E.A.M. DENTAL SPECIALISTS

In Partnership with

CLEAR ADVANTAGE ORTHODONTIC CLINIC

DR. SUZANNE CZIRAKI - ORTHODONTIST

Orthodontic Patient Referral Form

Date: _____

Patient Name: _____ D.O.B.: _____ Parent/Guardian: _____

Address: _____ City/Prov.: _____ Postal Code: _____

Home: _____ Phone: _____ Email: _____

Referring Doctor: _____ Referring Office Email: _____

Referring Office Address: _____ Phone: _____

X Rays: ☐ Emailed ☐ Not Provided

Reason for referral:

_____

_____

_____

_____

_____

_____

- ☐ Invisalign
- ☐ Braces
- ☐ Early Treatment for Children
- ☐ TMD treatment
- ☐ Pre-prosthetic treatment
- ☐ Accelerated

- There is no charge for initial consultation.
- During the consultation, we will describe your orthodontic problem and it's severity, estimate treatment time and orthodontic fees.
- If you are unable to keep the appointment, Please call us within 24 hours notice.
- We look forward to seeing you!

Please, email or refer online through our website. Thank you for the courtesy of your referral!

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