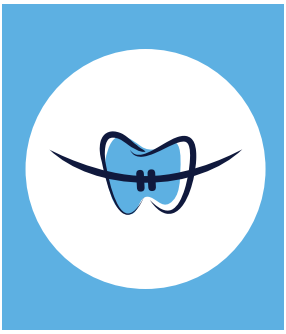

Fairfield Orthodontics

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Office (707) 428 - 3200 FAX (707) 428 - 6045

info@fairfieldortho.com

Date: _____

Referred By Dr. _____

Introducing My Patient _____

Pt. Contact Info _____

_____

_____

- ❍ Please Evaluate for Early or Interceptive Treatment
- ❍ Please Evaluate for Full Orthodontics
- ❍ Please Evaluate for Craniofacial Orthopedics
- ❍ Pre-prosthetic Treatment Needed
- ❍ Other

Remarks _____

_____

_____

_____

_____

- ❍ Please Call Me Before Proceeding with Treatment
- ❍ Radiographs for your evaluation have been:
  - ❍ Emailed to info@fairfieldortho.com
  - ❍ Given to the patient to bring to the appointment
  - ❍ Mailed to your office
    - ❍ Please return after seeing patient
    - ❍ Keep for your record

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