Captain Dental

Orthodontics Referral Form

4585 Stevens Creek Blvd, Ste 101, Santa Clara , CA, 95051
Tel # 408-826-4676 www.captaindental.com

INTRODUCING: _____
patient name *date of birth*

The patient is being referred for:

- ☐ General Orthodontic Evaluation
- ☐ Early Interceptive Treatment
- ☐ Invisalign Consultation

Comments: _____

_____

_____

Panoramic Radiographs (check all that apply):

- ☐ Emailed: frontdesk.sc@captaindental.com
- ☐ Given to Patient
- ☐ Please Take

Referring Doctor: _____
name *date*

Referring Clinic: _____ _____
phone number *email address*