



PARKER ORTHODONTICS

Joseph D Parker DDS, MSD

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Referred by Dr. _____

Patient Name _____

DOB _____ Date _____

Patient Phone Number _____

Parent Name _____

Referred for the following:

- General Orthodontic Evaluation
- Early / Interceptive Treatment Evaluation
- TMJ / Occlusion Evaluation
- Crowding / Spacing
- Crossbite / Functional Shift
- Early Loss of Teeth / Space Maintenance
- Growth / Skeletal Imbalance
- Pre-Prosthetic / Implant Site Development
- Impacted Teeth / Surgical Orthodontics
- Invisalign / Clear Braces
- Other _____

Remarks

Panoramic: Date _____

- Please take Emailed Mailed Given to patient
- Please call the referring dentist before proceeding with treatment
- Spanish translation needed

Complimentary Initial Consultation

www.ellensburgortho.com



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