dr. john kershman
ORTHODONTICS AND PERIODONTICS

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ORTHODONTIC REFERRAL

Introducing _____ Tel.: (H) _____

Tel.: (B) _____

From Dr. _____ Tel.: _____

Referred for:

- ☐ Complete Orthodontic Treatment
- ☐ Limited Treatment

Special Comments _____

_____

_____

Patient has had:

- ☐ Recent Radiographs:
  - ☐ PAs No. or Films Date: _____
  - ☐ Panorex Date: _____

X-Ray Sent:

- ☐ By mail
- ☐ With patient
- ☐ By email _____

An appointment for an orthodontic evaluation has been reserved for: Date: _____ SUBMIT FORM

PLEASE NOTE: If unable to keep this appointment please advise us at least 24 hours before scheduled time. Thank you.