FUSION ORTHODONTICS

REFERRAL FORM

Hessam Rahimi, *DDS, DMSc, MBA*
Diplomate, American Board of Orthodontics

Date: _____

Please Email this form to manager@fusionorthodontics.com or Fax it to (972) 666-4944
To reserve an appointment, please visit www.fusionorthodontics.com or call (972) 666-5363

Referring Doctor

Office Name: _____
Dentist Name: _____
Office Phone (Website): _____

Patient Information

Patient Name: _____
Cell Phone (Email): _____
Date of Birth: _____

Reason for Referral:

- ☐ Orthodontic Evaluation (Comprehensive, Phase I)
- ☐ Orthognathic Surgical Evaluation
- ☐ Limited Pre-prosthetic | Pre-Implant Orthodontic Evaluation
- ☐ CBCT 3D X-ray (i-CAT™) ☐ Intraoral 3D Scan (iTero®)

The patient is interested in:

☐ Conventional Braces ☐ Clear Braces ☐ Aligners (Invisalign®) ☐ Brava™ by BRIUS™

Comments:

_____
_____
_____
_____

☐ Records Emailed to **manager@fusionorthodontics.com** ☐ Sent with patient ☐ None

SEND