

SONS & DAUGHTERS



— ORTHODONTICS —

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Specializing in Braces for Children and Adults

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Date: _____

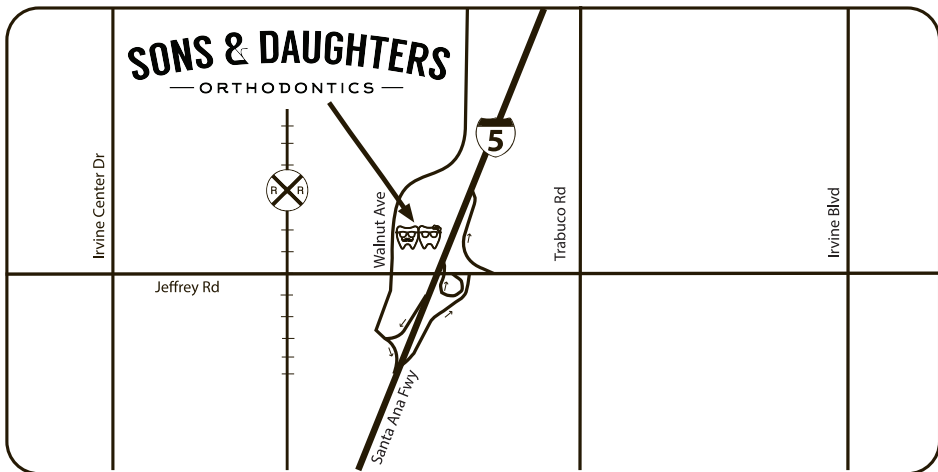
Referring Dr. _____ Phone: _____

Introducing my patient _____

Patient has been referred for the following:

- | | |
|--|---|
| <input type="checkbox"/> General Orthodontic Evaluation | <input type="checkbox"/> Overjet |
| <input type="checkbox"/> Habit Correction Treatment | <input type="checkbox"/> Facial Esthetics |
| <input type="checkbox"/> Facial Growth Disorder | <input type="checkbox"/> Impacted Teeth |
| <input type="checkbox"/> Early Interceptive Treatment | <input type="checkbox"/> Dental Spacing |
| <input type="checkbox"/> Restorative / Prosthetic Concerns | <input type="checkbox"/> Cross Bite |
| <input type="checkbox"/> Orthognathic Surgical Evaluation | <input type="checkbox"/> Ectopic Eruption |
| <input type="checkbox"/> Minor Tooth Movement | <input type="checkbox"/> Deep Bite |
| <input type="checkbox"/> Dental Crowding | <input type="checkbox"/> Invisalign Treatment |
| <input type="checkbox"/> Open Bite | <input type="checkbox"/> Missing Teeth |

Special Instructions or remarks: _____



Conveniently located in the Orange Tree Square Shopping Center