PERRIN ORTHODONTICS

REQUEST FOR AN ORTHODONTIC CONSULTATION

Patient Name | Gender | D.O.B. *(MMDDYY)*

Parent's Names

Phone # (Home) | Phone # (Work/Cell)

Please fill out the following information to help us in providing your patient with the best possible care

Preferred Principal Orthodontist: ☐ No Preference ☐ Dr. Paxon ☐ Dr. Perrin

Reason for referral

Date of last exam and cleaning

Is there any dental work currently required?

Has a panoramic radiograph been taken in the last year? Please forward by email if possible.

☐ Please call the patient to schedule an appointment

☐ Patient will call

☐ An appointment has been made for Date *(MMDDYY)*

Referred by Dr. (Please Print) | Date *(MMDDYY)*

If you have any questions, please feel free to contact our office.

1000 Main Street
Penticton, BC V2A 5E5

Phone: 250-493-4118 • Fax: 250-490-4848
drperrin@shawbiz.ca • www.perrinorthodontics.com