
***Please complete referral form and email to Info@BrierCreekOrtho.com
or fax form to 919-544-9002.***

Patient Name: _____ Phone: _____

Date of Birth: _____ Age: _____ Gender: M / F

Contact Person: _____ Email: _____

Date of most recent:

Cleaning and exam: _____ Panorex: _____

If available, please email recent panorex to Info@BrierCreekOrtho.com

Patient Cleared for Orthodontic Treatment:

☐ Yes ☐ Restorative work needed **prior** to orthodontic treatment

Periodontal condition is:

☐ Good ☐ Fair ☐ Poor

Notes/Comments: _____

Referring Dentist's Name: _____

Signature: _____ Date: _____

10411 Moncreiffe Road, Suite 105A Raleigh, NC 27617

Tel: (919) 544-9700 | Fax: (919) 544-9002

Email: Info@BrierCreekOrtho.com

www.BrierCreekOrtho.com

