embrace
ORTHODONTICS

Dr. Catherine McLeod
CERTIFIED SPECIALIST IN ORTHODONTICS

NEW PATIENT REFERRAL FORM

Referring Doctor Information

Date: _____

Referred by Dr: _____

Practice name: _____

Radiographs: _____

- ☐ Emailed / Mailed
- ☐ Please return
- ☐ Given to patient
- ☐ Attached
- ☐ Please take as needed

Restorative work to be completed: _____

_____

Periodontal work to be completed: _____

_____

Kindly send any periodontal referrals prior to requesting an orthodontic consultation.

Orthodontic treatment request details: _____

_____

_____

Patient prefers: ☐ **Invisalign** ☐ **Braces**

Patient information

Name: _____

Address: _____

Email: _____

Tel: _____ **Other:** _____

DOB: _____

☐ **Male** ☐ **Female** ☐ **Other:** _____

Responsible party name : _____

_____

- ☐ Send copy of form to patients email address
- ☐ Send copy of form to patients mailing address

Insurance information

Insurance provider: _____

Policy # _____ ID# _____

Policy holder name: _____

Policy holder DOB: _____

☐ General Insurance Form attached

☐ Please send more referral forms

PLEASE SELECT DESIRED LOCATION

☐ **Halifax -** Located two floors below Park Lane Dental Specialists
Embrace Orthodontics
402-5657 Spring Garden Rd
Halifax, NS, B3J 3R4
Phone / Fax: 902-817-6453
embraceortho@embracelifesmiling.com

☐ **Bridgewater**
Embrace Orthodontics
402A King St
Bridgewater, NS, B4V 1A9
Phone / Fax: 902-817-6453
embraceortho@embracelifesmiling.com

Thank you for your kind referral. We are happy to accept referrals by phone, fax or email.

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