



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@embracelivesmiling.com

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

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

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