Orthodontic Referral

Dr. Mark D. Pus, Bsc., DDS, MCID, FRCD(C)

Clarence Street DENTAL Group

Patient's Name: ______________________________

Parents' Names: ______________________________

DOB: ______________________________

Phone #: ______________________________

Email Address: ______________________________

Referring Doctor: ______________________________

Clinic Phone #: ______________________________

Clinic Email: ______________________________

Type of treatment:

❑ Braces ❑ Clear Braces ❑ Invisalign ❑ Retainer

Has the patient had orthodontic treatment previously? ❑ Yes ❑ No

Please explain: ______________________________

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X-rays to be emailed at time of referral: ______________________________

***At Clarence Street Dental, we require payment at the time of service. We will submit to your insurance carrier on your behalf for your reimbursement. Our office is happy to make financial arrangements with you for monthly payments using Visa, Mastercard, or cheques. We regret to inform you that we do not accept ODSP or HSO as a form of payment.**

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