

# Orthodontic Referral

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Clarence Street  
DENTAL.com

~ Own Your Smile ~

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.**