Nichols Orthodontics, Inc.

Laura Nichols, D.D.S, M.S.

Orthodontics for Children & Adults

Referring Doctor_____ Date _____

Patient Name_____

Address_____

Patient Phone_____ Birth Date _____

Reason for referral:

- O Complete Orthodontic Evaluation
- O Limited Orthodontic Evaluation

Radiographs:

- O Full mouth x-ray available
- O Panoramic radiograph available
- O CBCT available
- O Please take a new CBCT

Remarks:

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Email: x-ray@nicholsorthodontics.com • www.nicholsorthodontics.com