SIERRA DENTAL

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Dr. Jocelyne Shim

Certified Specialist in Orthodontics

Referring Dentist:_____

Phone: _____Email:_____

We are referring:

Patient: _____

Address:_____

Phone: (Cell)_____(Home)_____

Email:_____

Reason for Referral:_____
_____
_____
_____

Relevant History: (Indicate any special factors – either dental or medical- such as known allergies, and specific medical problems relevant to diagnosis and treatment)

_____
_____
_____
_____

____ Please call patient ____ An appointment has been made

Referral sent by email on (date): _____