



Sudbury Town Square | 29 Hudson Road, Suite 3220, Sudbury, MA 01776
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Patient Referral to:

Saam Bozorg DMD
Orthodontist

Patient: _____ **Phone:** _____

Referral by Dr. _____ **Phone:** _____

- Please evaluate for comprehensive orthodontic Treatment
- Please perform a limited exam for: _____
- Please evaluate for Pre-prosthetic treatment for: _____

Please Evaluate for:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Molar uprighting |
| <input type="checkbox"/> Overjet | <input type="checkbox"/> Overbite |
| <input type="checkbox"/> Crossbite | <input type="checkbox"/> Open bite |
| <input type="checkbox"/> Retainers | <input type="checkbox"/> Space maintenance |
| <input type="checkbox"/> Spacing | <input type="checkbox"/> Other: _____ |

Radiographs

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> With Patient | <input type="checkbox"/> Mailed on: _____ |
| <input type="checkbox"/> No X-rays | <input type="checkbox"/> E-mailed on: _____ |

Comments:

- Please bring this referral form with you to your first appointment.
- All patients under 18 should be accompanied by an adult.
- If unable to keep your appointment, please notify the office as soon as possible.

