# San Diego Dental Specialty Center

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Specialist in Orthodontics and Dentofacial Orthopedics

☐ Must bring Referral
☐ Minor must be accompanied by parent or legal guardian

Patient Name:_____ Home Phone:_____ Work Phone:_____

Email:_____ Referring Office / Doctor:_____

Phone:_____ Appointment Date:_____ Time:_____

Patient concern:_____ Refferred For:_____

❑ Crowding ❑ OpenBite ❑ OverBite ❑ Deep OverBite ❑ CrossBite ❑ Facial Growth Problems

❑ Missing Teeth ❑ Overjet ❑ Impacted Tooth ❑ TMJ Dysfunction ❑ Spacing ❑ Inadequate "Jaw" Relationship

❑ Forced Eruption for Crown or Bridge ❑ Other

Comments:_____

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If for any reason you cannot make this appointment, Please let us know at least 48 hours in advance