125 SW Military Drive
San Antonio, Texas 78221 P: 210-944-4906
Fax or Email to: F: (210) 610-5270 or 210-610-6415
E: mdaniels@sscdc.org or rmunoz@sscdc.org

Referral Form

Patient's Information:	**Referring Office Information:**
Patient Name:	Office Name:
DOB:	Office Location:
Parent/ Legal Guardian:	Phone:
Phone:	Email:

Reason for Referral:

ORTHODONTICS

☐ Early Treatment (Primary/Mixed Dentition) ☐ Full Treatment (Permanent Dentition)

☐ Other: _____

If X-Rays have been taken, please enclose with the referral form or email before consultation:
mdaniels@sscdc.org or rmunoz@sscdc.org

THIS CERTIFIES THAT YOUR PATIENT COMPLETED THE FOLLOWING:

□Dental Exam □Dental Cleaning □No Cavities □Cavities, how many?_____

Appt. Date: _____ Appt Time: _____

Referring Doctor's Name: _____ Date: _____

We are grateful for your confidence in our practice and understand that your patients are important. All patients will be instructed to return to their regular dental home for their routine check-ups once treatment is completed. Thank You!