



GARRETT ORTHODONTICS

GO for the smile of a lifetime

1040 E. GRAND AVENUE
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Visit us at www.garrettortho.com

REFERRING DOCTOR _____

PATIENT NAME _____

AGE _____ **PATIENT PHONE NUMBER** _____

APPT DATE(S) _____

For the evaluation of the following:

- | | |
|--|---|
| <input type="checkbox"/> GENERAL ORTHODONTIC EVALUATION | <input type="checkbox"/> INVISALIGN® |
| <input type="checkbox"/> EARLY/INTERCEPTIVE TREATMENT | <input type="checkbox"/> RETAINERS |
| <input type="checkbox"/> PRE-PROSTHETIC/IMPLANT SITE DEVELOPMENT | <input type="checkbox"/> IMPACTED/MISSING TEETH |
| <input type="checkbox"/> OTHER: | <input type="checkbox"/> SURGICAL ORTHODONTICS |

Comments:

Complimentary Initial Consultation

