



the smart
ORTHODONTIC GROUP



Patient _____

Phone No. _____

Referred by _____

Date _____

Reason ☐ Comprehensive Orthodontic Examination

☐ Specific Concerns:

Recent panoramic x-ray ☐ Unavailable, please take new film

☐ Available, accompanying patient

☐ Available, mailed to your office

☐ Available, will send if requested

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2302 S. Union Ave,
Suite B14
(253) 752-3949
(253) 752-6392 Fax

Gig Harbor
3519 56th St,
Suite 120
(253) 851-6789
(253) 851-9558 Fax

Belfair
131 NE Roy Boad Rd,
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