S. (Sean) Sefidpour, DDS, MSD, MSME

Member
American Association of
Orthodontists

Orthodontic Referral: ____________________

Date of Referral: ________________________

[white/Patient copy]
[canary/Orthodontist copy]
[pink/Referring Doctor copy]

Dr. ____________________________ has referred you for an initial orthodontic evaluation.
This evaluation is complimentary.

Patients Name: ______________________________

Age: ______________________________

Phone #: ______________________________

Concerns/Requests: ______________________________

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This initial visit will involve a visual examination, which will include the recording of characteristics specific to your problem. We will discuss our findings with you, then explain the treatment options, timing, duration and expense.

We will provide you with the information necessary to make an informed decision regarding care.

Please call for an appointment.

✸ **Rocklin Location** 6950 Destiny Dr Rocklin, CA 95677 T 916.624.2175 F 916.624.4193
✸ **Granite Bay Location** 4150 Douglas Blvd., Suite B, Granite Bay, CA 95746 T 916.774-6986 F 916.774-6533

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