



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: _____

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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