YAKIMA ORTHODONTICS

Joseph D Parker DDS, MSD
OFFICE 509-248-5181 FAX 509-575-7967 | yakimaortho@gmail.com

Referred by Dr._____

Patient Name_____

DOB_____ **Date**_____

Patient Phone Number_____

Parent Name_____

Referred for the following:

- ☐ General Orthodontic Evaluation
- ☐ Early / Interceptive Treatment Evaluation
- ☐ TMJ / Occlusion Evaluation
- ☐ Crowding / Spacing
- ☐ Crossbite / Functional Shift
- ☐ Early Loss of Teeth / Space Maintenance
- ☐ Growth / Skeletal Imbalance
- ☐ Pre-Prosthetic / Implant Site Development
- ☐ Impacted Teeth / Surgical Orthodontics
- ☐ Invisalign / Clear Braces
- ☐ Other_____

Remarks

Panoramic: **Date**_____

☐ Please take ☐ Emailed ☐ Mailed ☐ Given to patient

☐ **Please call the referring dentist before proceeding with treatment**

☐ **Spanish translation needed**

Complimentary Initial Consultation

www.yakimaortho.com

YAKIMA
ORTHODONTICS

Joseph D Parker DDS, MSD
OFFICE 509-248-5181 FAX 509-575-7967
yakimaortho@gmail.com
1107 Summitview Ave, Yakima, WA 98902

www.yakimaortho.com

Member
American
Association of
Orthodontists