



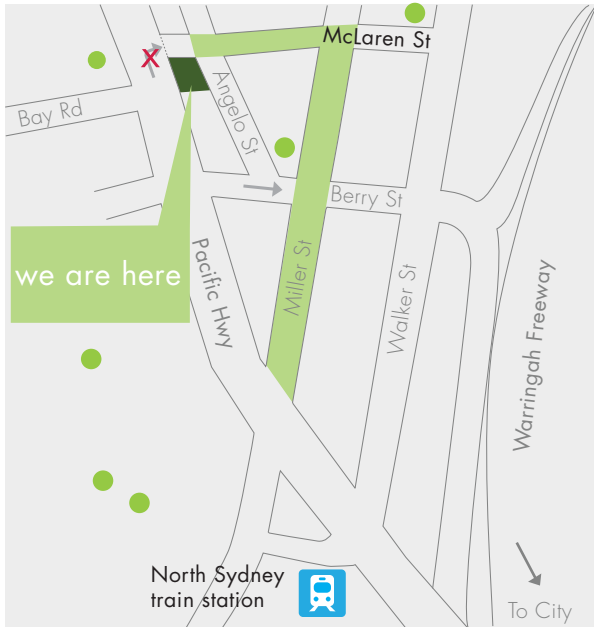
JUST ORTHODONTICS

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● schools

PATIENT REFERRAL

PATIENT _____ D.O.B _____

ADDRESS _____

_____ PHONE _____

REFERRING DOCTOR _____

Signature _____ Date _____

PURPOSE FOR REFERRAL

- Class II
- Class III
- Crowding
- Other (please specify) _____
- Crossbite
- Deep bite
- Open bite
- Spacing
- Missing/Extra teeth
- Impacted teeth

COMMENTS

Thank you for choosing our practice.
Please call or email to schedule an appointment for your initial consultation.
Please remember to bring this with you.

Dr JUSTIN WS FONG

BDS Hons (Syd) MDSc (Syd) MOrth RCS (Edin) MRACDS (Ortho)