BEAM ORTHODONTICS

REQUEST FOR: ☐ ORTHODONTIC CONSULT ☐ OROFACIAL MYOFUNCTIONAL THERAPY CONSULT (PENTICTON ONLY)

PLEASE SELECT DOCTOR: ☐ DR. JONATHAN PAXON (PENTICTON OR WEST KELOWNA) ☐ DR. JEFF STEWART (WEST KELOWNA ONLY) ☐ NO DOCTOR PREFERENCE

Patient Name | Gender | D.O.B. (MMDDYY)

Parent's Names

Phone # (Home) | Phone # (Work/Cell) | Email

Mailing Address

Please fill out the following information to help us in providing your patient with the best possible care

Reason for Referral

Date of last exam and cleaning

Is there any dental work currently required?

Has a panoramic radiograph been taken in the last year? Please forward by email if possible.

☐ Please call the patient to schedule an appointment
☐ Patient will call
☐ An appointment has been made for Date *(MMDDYY)*

Referred by Dr. (Please Print) | Date *(MMDDYY)*

If you have any questions, please feel free to contact our offices:

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