NRH ORTHODONTICS

Where beautiful smiles are made

B. Fallah, D.D.S., M.S.D.

Date: _____
Referring Dentist: _____
Phone: _____ **Email:** _____

Patient Information

- **Name:** _____ **Date of Birth:** _____
- **Phone:** _____
- **Address:** _____
- **Email:** _____
- **Parent/Guardian (if minor):** _____

Reason for Referral

(Please check all that apply)

☐ Crowding ☐ Spacing ☐ Overbite ☐ Underbite ☐ Crossbite ☐ Open bite ☐ Jaw alignment
☐ Early orthodontic evaluation
☐ Other: _____

Radiographs/Records Provided:

Panoramic X-ray Date_____

Insurance Information

Primary Insurance Provider_____

Subscriber Name & DOB_____

Member ID/ Policy Number_____

Group Number_____ Employer_____

Insurance Phone Number_____

Additional Notes or Concerns_____

_____

_____

Thank you for your referral and trust in our orthodontic care. We look forward to serving your patient !

8601 Mid Cities Blvd.
North Richland Hills, TX 76182

Phone: (817) 581-8881
Fax (817) 581-4337

www.nrhorthodontics.com