

# FIRST IMPRESSION

ORTHODONTICS

*Smile with confidence*

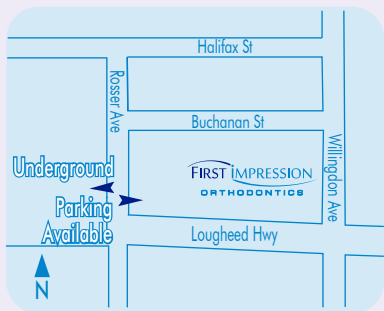
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Initial consultations are **FREE**

## Orthodontic Referral

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Phone number home \_\_\_\_\_ work \_\_\_\_\_

Email \_\_\_\_\_

Please examine this patient regarding \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring Doctor \_\_\_\_\_

Date \_\_\_\_\_ Doctor phone number \_\_\_\_\_

Doctor email \_\_\_\_\_

Doctor's address \_\_\_\_\_

Radiographs:  Attached,  With Patient,  Emailed / Mailed separately,  None

Please call us or submit this form via Fax or Email. Thank you!

Refer to us online at: [www.fiorthodontics.com/appointments](http://www.fiorthodontics.com/appointments)

www.fiorthodontics.com