Dr. R. Bruce McFarlane
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Orthodontic Referral

Patient _____ Parent/Guardian_____

Birth Date_____ Telephone_____

Address _____ Email _____

_____

Referring Dentist _____

Telephone_____ Email_____

Panorex Available □ Panorex Emailed □

Reason for Referral:

Dr. R. Bruce McFarlane
Certified Specialist in Orthodontics
Diplomate: American Board of Orthodontics