



# SPARKLE

## ORTHODONTICS

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Referring Doctor: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Patients Name: \_\_\_\_\_ Referral Date: \_\_\_\_\_

### Dental Details

Last Dental Cleaning: \_\_\_\_\_ Last Pano: \_\_\_\_\_

Has all dental treatment been completed?  No  Yes

### Areas of Concern

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Orthodontic Evaluation | <input type="checkbox"/> Braces       |
| <input type="checkbox"/> Surgical Evaluation    | <input type="checkbox"/> Aligners     |
| <input type="checkbox"/> Early Intervention     | <input type="checkbox"/> Other: _____ |

Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Please Call

- Before Consult       After Consult       Before Starting Treatment



[www.sparklevaorthodontics.com](http://www.sparklevaorthodontics.com)

Please bring this form to your appointment. Thank you!  
The American Association of Orthodontists recommends an evaluation at the age of 7.