ORTHODONTICS
Audrey Yoon, DDS, MS
SMILE DESIGN & BEYOND

REFERRAL FORM

Date _____

From the Office of Dr. _____

Doctor's Phone No : _____

Dear Dr. Yoon,

I have the pleasure of referring _____

to your office for

- ☐ Orthodontic Consultation
- ☐ Pediatric Dentistry
- ☐ Sleep Apnea
- ☐ Oral Appliance for Sleep Apnea
- ☐ Others : _____

_____

Treatment plan (such as orthognathic surgery, implants, crowns, sleep apnea appliances) :

_____

Last Cleaning/Scaling Date : _____

PATIENT'S INFORMATION

First Name: _____ Last Name: _____

DOB: _____ Phone No: _____

Email: _____ Parent/Guardian: _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

☐ **L.A. OFFICE**
Tel: 213.383.3460
Fax: 213.383.3433
3460 Wilshire Blvd. #104
Los Angeles, CA 90010
www.draudreyyoon.com

☐ **BELLFLOWER OFFICE**
Tel: 562.804.1468
Fax: 562.866.1177
16424 Bellflower Blvd.
Bellflower, CA 90706
www.smilesbydryoon.com

☐ **REDWOOD CITY OFFICE**
Tel: 650.402.2069
Fax: 650.440.7420
358 Marine Parkway #200
Redwood City, CA 94065
www.draudreyyoon.com

Any questions or report, please email to draudreyyoon@gmail.com