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
- ☐ TMJ
- ☐ Others : ______________________________

____

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

____

Last Cleaning/Scaling Date : ______________________________

Comments: ____

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I have given a copy of this referral slip to the patient or parents of the patient on this date. They will call your office for an appointment.

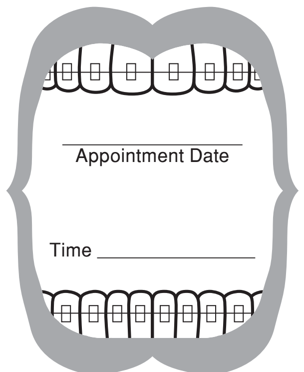
THE BRACE PLACE
& Kids Dentistry

AUDREY YOON, D.D.S., M.S.

Practice Limited to
Orthodontics and Kids Dentistry

16424 Bellflower Blvd.
Bellflower, CA 90706

Tel. 562-804-1468
Fax. 562-866-1177



Patient's Copy

Date ____________________

From the Office of Dr. ____________________

Doctor's Phone No : ____________________

Dear Dr. Yoon,

I have the pleasure of referring ____________________

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- ☐ Orthodontic Consultation
- ☐ Pediatric Dentistry
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Last Cleaning/Scaling Date : ____________________

Comments: ____________________

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Confidential Comments: ____________________

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Referring Doctor's Copy