



HAVEN ORTHODONTICS



Brittany Fischer, DDS, MS

Date _____ Patient Name _____

DOB _____ Patient Phone _____

Areas of Concern:

- | | |
|---|--|
| <input type="checkbox"/> Space Maintenance | <input type="checkbox"/> Clear Aligner Treatment |
| <input type="checkbox"/> Early Interceptive Treatment | <input type="checkbox"/> Interdisciplinary Treatment |
| <input type="checkbox"/> Comprehensive Orthodontics | <input type="checkbox"/> Other _____ |

Dental History:

- ☐ Date of last recall / cleaning _____
- ☐ Good dental health, no pending treatment
- ☐ Restorative or periodontal treatment pending

Comments:

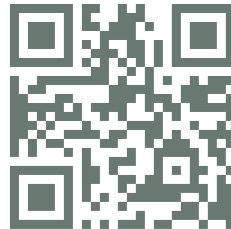
Referring Doctor _____

Phone _____ Email _____

Please send this referral with the patient or email to our office at hello@myhavenortho.com. Thank you for your referral.



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*schedule your
complimentary consult*

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