Carlos Flores-Mir

D.D.S., D.Sc., F.R.C.D. (c)
Registered Specialist in Orthodontics

124, 17010 90 Ave Edmonton, AB T5T 1L6
P. 780 484 1511 F. 780 481 4611
www.ruudortho.com
email: info@ruudortho.com

Patient's Name: _____

Address: _____

Cell: _____ Home: _____ D.O.B. ____ / ____ / ____
M D Y

Referred by Doctor: _____ Phone: _____

Appointment Date: _____

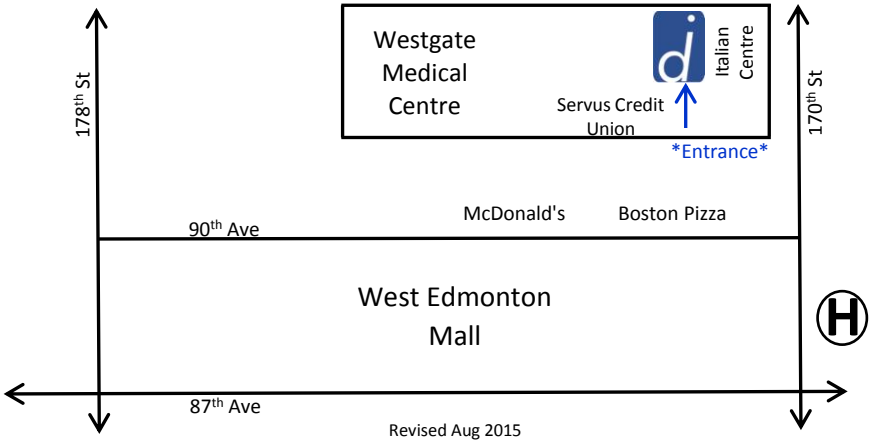
Reason for Referral: _____

_____

_____

Date of recent pan: _____ No Pan ☐

E-Mailed to: info@ruudortho.com YES ☐ NO ☐ Mailed YES ☐ NO ☐



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