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Dr. Benjamin Pliska
DDS, MS, FRCD(C)
Certified Specialist in Orthodontics

Patient: ______________________________

Address: ______________________________

DOB: ______ / ______ / ______ Phone: (home) ____________________ (work) ____________________

Concerning:

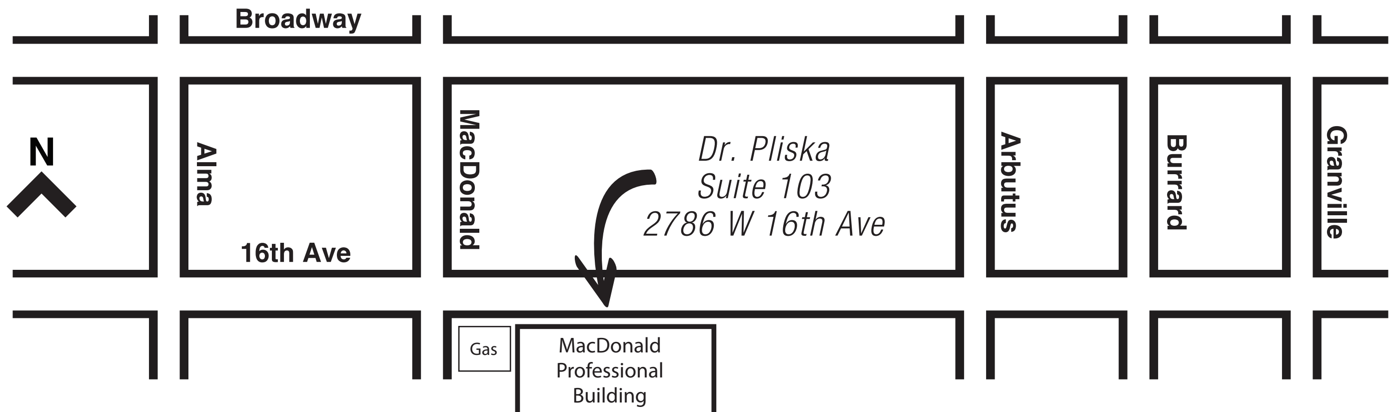
[ ] Please call to discuss [ ] Radiographs are being sent [ ] Radiographs enclosed / Please return

Referred by:

Dr: ______________________________ Date of Referral: ____________________

Address: ______________________________

Phone ______________________________ Fax ______________________________



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