THE Art OF BRACES

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SAOLY BENSON, DDS, MS

Board Certified Orthodontist
& Fine Art Photographer

702-800-4698

smile@theartofbraces.com

My appointment is: _____ @ _____ am/pm

[ ] Please contact patient

[ ] Patient will contact your office

Patient Name _____

Patient Date of Birth _____

Guardian/Parent (if applicable) _____

Phone Number _____

Email Address _____

Referral Concerns

[ ] General Orthodontic Exam

[ ] Specific Concerns: _____

_____

_____

Patient's current preventative, restorative, & periodontal health

[ ] In Good Dental Health

[ ] Patient Requires: _____

_____

Referring Doctor _____ Phone _____

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