Straight Up Smiles

YOUR ORTHODONTIC SPECIALISTS

Email: info@straightup-smiles.com

ALEX VO, DMD, MS

Patient Name: _____ **DOB:** _____

Patient Phone: _____

Parent/ Guardian Name: _____

Reason for Referral: *(circle options that apply)*

- Initial Examination/ Consultation
- Full Treatment
- Interceptive (early) Therapy
- Retainer
- Partial/ Limited Orthodontics
- Clear aligners (i.e. Invisalign/ Spark)

Circle one:

- Please call patient
- Patient instructed to call

Referral information:

Office/ Doctor Name:

Office Phone:

Doctor Comment:

9600 SW Capitol Hwy. Suite 140
Portland, OR 97219
503-922-7280

2330 NW Flanders St Suite 205
Portland, OR 97210
503-922-7280

Providing orthodontic treatment wherever you are in life.

www.straightup-smiles.com/referral