Cindy Adelstein, DMD

Masters, Academy of General Dentistry
Diplomate, Academy of Clinical Sleep Disorders Discipline

258 Main Street, Suite C-1, Buzzards Bay, MA 02532
(508) 759-2721 | Fax #: (508) 759-6216
canalside@42northdental.com

Patient Name:____

Patient Phone #:_______________ Patient DOB:__________________

Referring Doctor: ____

Address: ____

Phone #: ______________________ Fax #: ______________________

Referring for:

☐ Crowding ☐ Spacing ☐ Missing Teeth ☐ Impacted Teeth

☐ Crossbite ☐ Deep Bite ☐ Overjet ☐ Underbite

☐ Facial Growth Problems ☐ Pre-prosthetic Needs

☐ Sleep Apnea ☐ Snoring

☐ Other____

Sleep Test Completed? Y/N ☐ Sleep Test Present for Consultation

Teeth for Evaluation:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J

____

T S R Q P O N M L K
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Referral Notes:____

____

____

____

____

____

NOTE TO PATIENT: When calling to make your appointment, please have your medical/dental insurance information available. Please bring this referral and any X-rays with you to your appointment. After your specialty appointment is complete you will be referred back to your regular dentist for your continued care. If unable to keep your appointment, please notify us 24 hours in advance.