School of Dental Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

ORTHODONTIC DEPARTMENT

**Patient**: ______________________________ **Birthdate**: _____________

**To ensure quality dental care communication, please provide us with your general dentist information. This is especially important if you receive dental care outside of the school of dental medicine.**

**Dentist/Clinic Name**: _______________________________________________

**Address**: _________________________________________________________

_________________________________________________________

**Phone #**: ____________________________

** If you would like your dental office to forward any dental x-rays/information to us, please have it sent to: **sdmortho@ucdenver.edu**