



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**