

**Hessam Rahimi, DDS, DMSc, MBA**  
Diplomate, American Board of Orthodontics



Date: \_\_\_\_\_

Please Email this form to [garland@optimadentistry.com](mailto:garland@optimadentistry.com) or Fax it to (214) 432-1587  
To reserve an appointment, please visit [www.optimadentistry.com](http://www.optimadentistry.com) or call (972) 276-0159

**Referring Doctor**

Office Name: \_\_\_\_\_  
Dentist Name: \_\_\_\_\_  
Office Phone (Website): \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
Cell Phone (Email): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**Reason for Referral:**

- Orthodontic Evaluation (Comprehensive, Phase I)
- Orthognathic Surgical Evaluation
- Limited Pre-prosthetic | Pre-Implant Orthodontic Evaluation
- CBCT 3D X-ray (i-CAT™)     Intraoral 3D Scan (iTero®)

**The patient is interested in:**

- Conventional Braces     Clear Braces     Aligners (Invisalign®)     Brava™ by BRIUS™

**Comments:**

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\_\_\_\_\_

Records Emailed to [garland@optimadentistry.com](mailto:garland@optimadentistry.com)     Sent with patient     None