REQUEST FOR PATIENT CONSULTATION

Dr. Timothy Shaughnessy, D.D.S., M.S.
FORCE Int, Onl
P.O. Box 28068 • San Diego, CA 92198
(248) 850-1433

PATIENT NAME: ____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: _______________________ DATE RECORDS MADE: _____________________

PLEASE SEND ME:

Complete consultation, including diagnosis, treatment plan, mechanics plan, retention plan and suggested fee.

$300.00 U.S. per case

Note: A patient consent form must be included with the patient records. A copy of the consent form will be e-mailed to Dr. Shaughnessy along with all of the other patient records from D.E.T.

This consultation report does not constitute a contract between Dr. Timothy Shaughnessy (consultant) and the above named patient. No in-person Dr./patient relationship has ever been established between Dr. Timothy Shaughnessy and the above named patient. The enclosed case description and treatment plan are for educational purposes and describe one of the acceptable treatment options for this patient. The final decision regarding the diagnosis and treatment of the problem, as well as the cost, timing, and choice of appliances to be used, rest solely with the treating doctor. These decisions must be made in concert with the above named patient or parents, if said patient is a minor.

Payment to FORCE Int, Onl must be included with the records and order form

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NAME: ____

CREDIT CARD BILLING ADDRESS: ____

CITY: ____________________________ STATE/PROVINCE: _______________ ZIP/POSTAL CODE _____________

PHONE: (_______)___________________ FAX: (_______)__________________

E-MAIL FOR CONSULTS: ____

I WILL PAY BY: ☐ VISA ☐ MASTERCARD AMOUNT PAYABLE TO F.O.R.C.E., INT.: $___________________

ACCOUNT NUMBER: ____ EXP. DATE: _______________

SEC OR 3-DIGIT CODE: ________________ SIGNATURE: ____