Deerwood Orthodontics

ORTHODONTIC REFERRAL

PATIENT NAME		PATIENT D.O.B.	CONTACT OR RESPONSIBLE PARTY (if minor)	PHONE
REFERRED BY:	OFFICE:	DATE OF REFERRAL	RECENT X-RAYS SENT: ☐ PA's ☐ Panorex ☐ None	

REASON FOR REFERRAL:

☐ A. General Orthodontic evaluation

☐ B. Specific Concern (please check all that apply):

GENERAL

☐ Class I Malocc ☐ Crossbite(s) ☐ Openbite ☐ Impaction(s): _____

☐ Class II Malocc / Div 1 ☐ Space Maintenance ☐ Crowding ☐ Missing Teeth: _____

☐ Class II Malocc / Div 2 ☐ Excess Overjet ☐ Spacing

☐ Class III Malocc ☐ Excess Overbite ☐ Tongue/Thumb/Finger Habit

Additional Concerns:

Patient /Parent are concerned with problem (please check) ☐ Yes ☐ No ☐ Somewhat

X _____

DDS Signature

Date of exam _____ Patient seen by _ Doctor List

Brief description of problem:

Proposed Treatment Plan:

ORTHO

Procedure requested of Dentist (please check) ☐ Yes ☐ No

Treatment request enclosed (please check) ☐ Yes ☐ No

☐ Patient has scheduled records ☐ Patient placed on Recall Date of Recall _____

☐ Patient undecided about treatment ☐ Patient has no interest in treatment at this time

Additional Comments:

X _____

Orthodontist's Signature

☐ Patient did not schedule orthodontic appointment