



PATIENT NAME		PATIENT D.O.B.	CONTACT OR RESPONSIBLE PARTY (if minor)	PHONE
REFERRED BY:	OFFICE:	DATE OF REFERRAL	RECENT X-RAYS SENT: <input type="checkbox"/> PA's <input type="checkbox"/> Panorex <input type="checkbox"/> None	

REASON FOR REFERRAL:

A. General Orthodontic evaluation

B. Specific Concern (please ✓)

- G** Class I Malocclusion Crossbite(s) Openbite Impaction(s) _____
- E** Class II Malocclusion / Div 1 Space Maintenance Crowding Missing Teeth _____
- N** Class II Malocclusion / Div 2 Excess Overjet Spacing
- E** Class III Malocclusion Excess Overbite Tongue/Thumb/Finger Habit

R Additional Concerns: _____

A Patient/Parent are concerned with problem (please ✓) Yes No Somewhat

X _____
 DDS Signature

Date of exam _____ Patient seen by Dr. _____

Brief description of problem: _____

Proposed Treatment Plan: _____

- O** Procedure requested of Dentist (please circle) Yes No
- R** Treatment request enclosed (please circle) Yes No
- T** Patient has scheduled records Patient placed on Recall – Date of Recall _____
- H** Patient undecided about treatment Patient has no interest in treatment at this time
- O**

Additional Comments: _____

X _____
 Orthodontist's Signature

Patient did not schedule orthodontic appointment