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 ✓)

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: ____

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

X ____

DDS Signature

ORTHO

Date of exam ____________________ Patient seen by Dr. ____________________________

Brief description of problem: ____

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Proposed Treatment Plan: ____

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Procedure requested of Dentist (please circle) Yes No

Treatment request enclosed (please circle) 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: ____

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X ____

Orthodontist's Signature

☐ Patient did not schedule orthodontic appointment