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ORTHODONTICS

ORTHODONTIC REFERRAL FORM

Thank you for trusting us with your patient's smile!

PATIENT INFORMATION

First Name: _____ Last Name: _____

DOB: _____ Parent/Guardian: _____

Phone: _____ Email: _____

REASON FOR REFERRAL (check all that apply)

☐ Orthodontic Evaluation
☐ Early (Phase I) Evaluation
☐ Clear Aligner Consultation
☐ Crowding / Spacing
☐ Crossbite
☐ Overbite / Underbite
☐ Impacted Teeth
☐ Other: _____

Clinical Notes (optional):

ADDITIONAL INFORMATION Date of Last Cleaning: _____

Pending Dental Treatment (if any)_____

_____

Panoramic Radiograph:

☐ Pano included ☐ Will email ☐ Please contact our office

REFERRING OFFICE

Practice Name: _____

Referring Dentist: _____

Phone: _____ Email: _____

☐ Patient aware of referral ☐ Please call prior to scheduling

We'll contact the family and send your office a consultation summary. Thank you for your partnership!

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