SMILE DESIGN
ORTHODONTICS

Dr. Chandra M. Minor, DMD, Orthodontist

PATIENT REFERRAL

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DATE: _____

DR. _____ PHONE: _____

I am referring: _____

Patient's Phone: _____

To your office for: ☐ Treatment ☐ Consultation ☐ Other

REASON FOR REFERRAL:

- ☐ General Orthodontic Evaluation
- ☐ Crowding
- ☐ Spacing
- ☐ Crossbite
  - ☐ Anterior
  - ☐ Posterior
- ☐ Open Bite
- ☐ Deep Bite
- ☐ Impacted Tooth # _____
- ☐ Excessive Overjet
- ☐ Ectopic Eruption
- ☐ Space Maintenance
- ☐ Ceramic (Clear) Braces
- ☐ Clear Aligners (i.e. Invisalign)
- ☐ Habit Correction (Thumb/Finger/Tongue)
- ☐ Facial Esthetics
- ☐ Orthognathic Surgical Evaluation
- ☐ Pre-Prosthetic Alignment
- ☐ Missing Teeth
- ☐ Other _____

RESTORATIVE TREATMENT: ☐ is complete ☐ is underway ☐ is pending outcome of orthodontic findings

☐ Please call me before proceeding with treatment.
☐ I have sent radiographs for your evaluation.

Date of Most Recent Panoramic Radiograph: _____

Date of Last Cleaning: _____

NOTES: _____