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

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

DATE: ________________________