PATIENT REFERRAL

SMILE DESIGN
ORTHODONTICS

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DATE: _____

DR. _____ PHONE: _____

I am referring: _____ AGE: _____

Patient's Phone: _____

To your office for: ❑ Treatment ❑ Consultation ❑ Other

REASON FOR REFERRAL:

- ❑ General Orthodontic Evaluation
- ❑ Crowding
- ❑ Spacing
- ❑ Cross Bite
  - ❑ 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: _____

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