

DOCTOR INFORMATION

REFERRING DOCTOR'S NAME: _____ PRACTICE NAME: _____

DOCTOR'S PHONE: _____ OFFICE CELL OTHER IS IT OKAY TO CALL WITH QUESTIONS? YES NO

DOCTOR'S EMAIL ADDRESS: _____

PATIENT INFORMATION

PATIENT'S NAME: _____ MALE FEMALE D.O.B.: _____

IS IT OKAY TO CALL THE PATIENT TO SCHEDULE AN APPOINTMENT? YES NO

PATIENT'S PHONE: _____ OFFICE CELL OTHER

WHAT ARE YOUR SPECIFIC CONCERNS REGARDING THIS PATIENT? PLEASE CHECK ALL THAT APPLY.

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> CLASS II | <input type="checkbox"/> EXCESSIVE OVERJET | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> CLASS III | <input type="checkbox"/> CROWDING | _____ |
| <input type="checkbox"/> DEEP BITE | <input type="checkbox"/> TMD | _____ |
| <input type="checkbox"/> OPEN BITE | <input type="checkbox"/> IMPACTED TEETH | _____ |
| <input type="checkbox"/> CROSS BITE | <input type="checkbox"/> MISSING TEETH | _____ |

ANY ADDITIONAL DENTAL PROBLEMS? PLEASE CHECK ALL THAT APPLY.

- ORAL SURGERY PERIODONTAL ENDODONTIC IMPLANTS

ARE ANY OF THE FOLLOWING RADIOGRAPHS AVAILABLE TO BE SENT? PLEASE CHECK ALL THAT APPLY.

- PERIAPICALS PANORAMIC BITE WING FULL MOUTH

IN TERMS OF ORAL HYGIENE AND/OR PERIODONTAL HEALTH, IS THE PATIENT CLEARED TO PROCEED WITH ORTHODONTIC TREATMENT?

YES NO

PLEASE PROVIDE ANY ADDITIONAL INFORMATION YOU WANT US TO KNOW.

