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PATIENT REFERRAL

NAME ______________________

AGE ______ **PHONE** ______________________

EMAIL ______________________

REASON FOR REFERRAL:

- ☐ Teeth crowding
- ☐ Esthetics of smile
- ☐ Jaw growth and development
- ☐ Oral habit(s)
- ☐ Mouth too small for teeth/tongue
- ☐ Other: (indicate below)

RESTORATIVE & COSMETIC:

- ☐ All pre-orthodontic restorative treatment is complete
- ☐ Pre-orthodontic treatment yet to be completed: ______________________
- ☐ Post-orthodontic restorative treatment proposed: ______________________

REFERRING DOCTOR ______________________

email: ______________________

phone: ______________________ date ______________________

PATIENT MOTIVATION:

Patient/Parent's chief concern: ______________________

PERIODONTAL:

- ☐ No periodontal concerns

Oral Hygiene: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

- ☐ Specific periodontal concerns: ______________________

TMD: ☐ Patient has signs & symptoms of TMD, including: ______________________

SUBMIT THIS FORM **VIA:** **FAX** 906.483.0209