



Specialists in Orthodontics
for Adults & Children

Introducing _____ Date _____

Home # _____ Work # _____

____ Patient will call to schedule appointment

Appointment has been scheduled for _____

REFERRAL FOR:	(Please circle)		YES	NO
Initial Examination and Diagnosis	X-Rays Sent	Pano	_____	_____
		PA	_____	_____
Second Opinion		Ceph	_____	_____
See Other Remarks		Other	_____	_____

Remarks _____

____ Please call regarding this patient following your examination.

____ I would like to discuss this patient's treatment further.

INITIAL EXAM AND DIAGNOSIS

Orthodontic _____ Orthognathic _____ TMJ _____

Other _____

TO HELP US PREPARE

1. Is this a regular patient in your practice? _____
2. Does this patient have a significant medical history? _____
3. Is premedication needed? _____

Doctor: _____ Phone # _____

____ Please send more referral pads



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