Specialists in Orthodontics
for Adults & Children

Introducing:_____ Date _____

Home # _____ Work # _____

____ Contact parent(s) to set this appointment ____ Parent will call to schedule appointment

Appointment has been scheduled for _____

REFERRAL FOR: (Please circle)

Initial Examination and Diagnosis

Second Opinion

See Other Remarks

X-Rays Sent

	YES	NO
Pano	____	____
PA	____	____
Ceph	____	____
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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