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PATIENT REFERRAL

Referring Dentist: _____ Date: _____

Referring Dentist Phone #: _____

Patient Information

Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Home #: _____
(month/day/year)

Parent/Guardian Name: _____ Other #: _____

Referral Details

Reason for Referral:
- ☐ Crowding/Spacing
- ☐ Class 2 Malocclusion
- ☐ Class 3 Malocclusion
- ☐ Excessive overbite/overjet
- ☐ Impacted/Missing teeth # _____
- ☐ Crossbite _____
- ☐ Cosmetic
- ☐ 2nd Opinion
- ☐ Other _____

Radiographs are:
- ☐ Enclosed (keep/return)
- ☐ With patient
- ☐ Mailed separately
- ☐ No radiographs
- ☐ Emailed

Restorative work is:
- ☐ Completed
- ☐ Pending
- ☐ Required post orthodontic treatment

Appointment Details

- ☐ Please contact patient directly @ _____
- ☐ Patient will contact Impressions Orthodontics

Comments: _____