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Introducing ______________________________

Age ________ Patient's Phone (____) ______________________

Referred by ______________________ Date ____________

Reason for Referral:

- ☐ Orthodontic evaluation and treatment as indicated.
- ☐ Evaluation of the following:
  - ☐ Esthetics ☐ Crossbite-Anterior/Posterior
  - ☐ Crowding/Spacing ☐ Openbite/Deepbite
  - ☐ Skeletal disharmony ☐ TMJ dysfunction
  - ☐ Pre-prosthetic considerations
  - ☐ Other ______________________________

Comments ______________________________

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Radiographs Available:

Full Mouth Series ☐ Dated ______________________

Panoramic Type ☐ Dated ______________________

☐ Patient will bring ☐ Sent in mail

Thank you for this referral! A complete examination summary will be forwarded as soon as your patient is seen in our office.