PACIFICA ORTHODONTICS

REFERRAL

Dr. Peter Trinh

Date_____

Referring Dr. _____ Phone (____)_____

Introducing my patient _____

Patient age:_____ Patient phone (____)_____

Patient has been referred for the following:

☐ Orthodontic evaluation and treatment as indicated.

☐ Evaluation of the following:

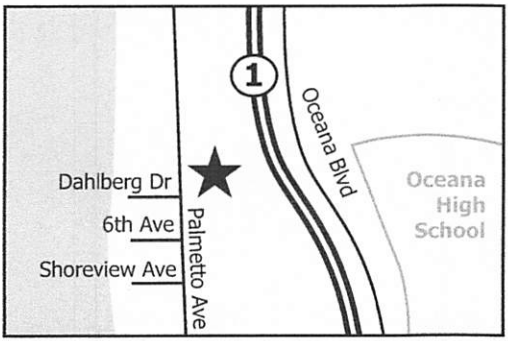
- ☐ Esthetics
- ☐ Crowding/Spacing
- ☐ Skeletal disharmony
- ☐ Pre-prosthetic considerations
- ☐ Other _____
- ☐ Crossbite-Anterior/Posterior
- ☐ Openbite/Deepbite
- ☐ TMJ dysfunction

Comments _____

_____

Dental History:

- ☐ Date of last cleaning and checkup _____
- ☐ Panoramic radiograph is available
- ☐ Restorative work needed



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