TOWN CENTER DENTISTRY

ORTHODONTIC REFERRAL FORM

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☐ Must bring Referral/Authorization form ☐ Minors (17 & under) must be accompanied by parent or legal guardian

Patient Name: ______________________ Date: __________

Referring Office/Doctor: ______________________ Telephone: ______________________

Patient concern: ______________________

REFERRED FOR:

___ CROWDING ___ SPACING ___ MISSING TEETH ___ CROSSBITE

___ OPENBITE ___ DEEP OVERBITE ___ IMPACTED TOOTH

___ OVER BITE ___ OVERJET ___ TMJ DYSFUNCTION

___ FACIAL GROWTH PROBLEMS ___ FORCED ERUPTION FOR CROWN OR BRIDGE

___ INADEQUATE "JAW" RELATIONSHIP ___ OTHER ______________________

COMMENTS ____

IF FOR ANY REASON YOU CANNOT MAKE THIS APPOINTMENT, PLEASE LET US KNOW AT LEAST 48 HOURS IN ADVANCE.