ELEVATED ORTHODONTICS
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PATIENT REFERRAL

Patient Name _____ Dental Appointment Date & Time: _____

Patient's Phone Number to Schedule Appointment _____

Referring Doctor _____ Referring Doctor Phone Number _____

THIS PATIENT IS BEING REFERRED FOR EVALUATION OF THE FOLLOWING:

- ☐ General Orthodontic Evaluation
- ☐ Adjunctive Orthodontics
- ☐ Clear Braces
- ☐ Dentofacial Orthopedics
- ☐ Early Interceptive Treatment
- ☐ Facial Growth Anomaly
- ☐ Habit Correction Treatment
- ☐ Impacted Teeth
- ☐ Invisalign
- ☐ Orthognathic Surgical Evaluation
- ☐ Pre-Prosthetic/Implant Site Development
- ☐ Temporo-Mandibular Disorder
- ☐ Other: _____

PATIENT'S CONCERNS:

- ☐ Crossbite/Functional Shift
- ☐ Crowding
- ☐ Growth/Skeletal Imbalance
- ☐ Minor Tooth Movement
- ☐ Missing Teeth
- ☐ Openbite
- ☐ Oral Habit/Tongue Thrust
- ☐ Overbite
- ☐ Overjet
- ☐ Pre-Prosthetic Alignment
- ☐ Space Maintenance
- ☐ Spacing
- ☐ Speech Disorder
- ☐ Other: _____

COMMENTS: _____

☐ **PLEASE CALL ME BEFORE PROCEEDING**

☐ **I HAVE SENT RADIOGRAPHS FOR YOUR EVALUATION**