Advanced Orthodontics

Patient Name: ....

Referred by: ....
(Doctor Name) (Office Telephone)

Please evaluate for Orthodontic correction of the following

- ☐ Crowding / Spacing
- ☐ Cross-bite / Functional Shift
- ☐ Oral Habit / Tongue Thrust
- ☐ Space Maintenance
- ☐ Pre-Prosthetic Alignment
- ☐ Other: ....

Comments:..

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- ☐ Please call me before proceeding with treatment.
- ☐ This patient has no caries or periodontal disease and is ready to start orthodontic treatment as needed.
- ☐ This patient still needs to complete restorative/periodontal work before starting orthodontic treatment.

Thank you for your kind referral!

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