



LAUREL
ORTHODONTICS
Jocelyn Defoe, DDS, MS

PATIENT REFERRAL

Introducing: _____

Appointment Date & Time: _____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

This patient is being referred for evaluation of the following:

- | | |
|---|--|
| <input type="checkbox"/> General Orthodontic Evaluation | <input type="checkbox"/> Impacted Teeth |
| <input type="checkbox"/> Adjunctive Orthodontics | <input type="checkbox"/> Invisalign® |
| <input type="checkbox"/> Clear Braces | <input type="checkbox"/> Orthognathic Surgical Evaluation |
| <input type="checkbox"/> Dentofacial Orthopedics | <input type="checkbox"/> Pre-Prosthetic/Implant Site Development |
| <input type="checkbox"/> Early Interceptive Treatment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Habit Correction Treatment | |

Patient Concerns:

- | | |
|---|---|
| <input type="checkbox"/> Crossbite/Functional Shift | <input type="checkbox"/> Overbite |
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Overjet |
| <input type="checkbox"/> Growth/Skeletal Imbalance | <input type="checkbox"/> Pre-Prosthetic Alignment |
| <input type="checkbox"/> Minor Tooth Movement | <input type="checkbox"/> Space Maintenance |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Spacing |
| <input type="checkbox"/> Openbite | <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> Oral Habit/Tongue Thrust | <input type="checkbox"/> Other: _____ |

Comments: _____

- Please call me before proceeding with treatment
 I have sent radiographs for your evaluation

Referring Dr.: _____ Date: _____

Referring Dr. Phone #: _____

www.LaurelOrtho.com

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