LAUREL ORTHODONTICS

JOCELYN DEFOE, DDS, MS

PATIENT REFERRAL

Introducing: _____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

This patient is being referred for evaluation of the following:

- ☐ General Orthodontic Evaluation
- ☐ Early Interceptive Treatment
- ☐ Habit Correction Treatment
- ☐ Other: _____
- ☐ Impacted Teeth
- ☐ Pre-Prosthetic/Implant Site Development
- ☐ Orthognathic Surgical Evaluation
- ☐ Other: _____

Patient Concerns:

- ☐ Crossbite/Functional Shift
- ☐ Crowding
- ☐ Growth/Skeletal Imbalances
- ☐ 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 with treatment
- ☐ I have sent radiographs for your evaluation

Referring Dr.: _____ Date:_____

Referring Dr. Phone: _____

Referring Dr. Email: _____

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