SHINE
ORTHODONTICS

ORTHODONTIC REFERRAL FORM

Referring Office Information:

DATE

REFERRING OFFICE

DENTIST NAME

Patient Information:

PATIENT'S NAME

DATE OF BIRTH

GUARDIAN'S NAME(S)

PHONE NUMBER

EMAIL ADDRESS

DATE OF LAST CLEANING

RESTORATIVE WORK PLANNED? ☐ YES ☐ NO

Referred For:

- ☐ COMPREHENSIVE ORTHODONTIC EVALUATION
- ☐ EARLY INTERCEPTIVE TREATMENT
- ☐ INVISALIGN CONSULTATION
- ☐ SPACE MAINTENANCE
- ☐ PRE-PROSTHETIC/ PRE-IMPLANT TREATMENT
- ☐ PRE-ORTHOGNATHIC SURGERY
- ☐ TMJ/TMD

Clinical Concerns:

- ☐ CROWDING
- ☐ SPACING
- ☐ CLASS II
- ☐ CLASS III
- ☐ OVERJET
- ☐ OVERBITE
- ☐ OPEN BITE
- ☐ CROSSBITE
- ☐ IMPACTED TEETH
- ☐ CONGENITALLY MISSING TEETH
- ☐ SKELETAL/GROWTH IMBALANCE
- ☐ MAXILLARY CONSTRICTION
- ☐ SPEECH CONCERNS
- ☐ AIRWAY/ BREATHING CONCERNS

COMMENTS

SIGNATURE

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