Harwell & Cook ORTHODONTICS

smile out loud

Patient Referral Form

Name: _____

DOB: _____ Age: _____

Parent Name: _____ Phone: _____

Email: _____

Date Referred: _____

Referring Dr.: _____ Office: _____

Clearance for Orthodontics: ☐ Yes ☐ No

If No, what needs to be done prior to starting treatment?

Referral Concerns for Orthodontic Treatment (please check):

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

Notes:

Please bring this form with you to your appointment. We look forward to meeting you!

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