

**Referring doctor's information:**

Date:

Doctor:

Office Phone:

Your Email:

Other Dental Specialists

Providing Care for Patient:

**Introducing:**

Patient:

Patient prefers to be called:

Parent/Guardian:

Home Phone:

Work Phone:

Cell Phone:

May we call this patient to  
schedule an examination?

Yes      No

**Please evaluate for:**

Phase One Treatment

Phase Two Treatment

Full Treatment (If no Phase One)

Invisalign

**Please indicate any specific concerns you have.**

Arch Form

Excess maxillary exposure

Class One

Habit

Class Two

Impacted teeth

Class Three

Implant preparation

Crossbite

Molar uprighting

Crowding w/potential for extraction

Profile concerns

Crowding w/potential for expansion

Protrusive teeth

Deep bite or open bite

Spacing

Diastma

Tooth/crown exposure

Esthetics-alignment

Potential for orthodontic and orthognathic surgery

**COMMENTS:**