orthodontics

SmileWorkshop®
DENTAL SPECIALISTS

3325 SOUTH GEORGIA ST • SUITE 200 • AMARILLO, TEXAS 79109 • 806-410-2220

patient referral

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

Please call to schedule your patient's appointment

Introducing: _____ Patient Phone: _____

Appointment Date & Time: _____

Date: _____ Referring Dr. _____ Phone: _____

This patient is being referred
for evaulation of the following:

Patient's concerns:

- ☐ General Orthodontic Evaluation
- ☐ Adjunctive Orthodontics
- ☐ Clear Braces
- ☐ Early Interceptive Treatment
- ☐ Habit Correction Treatment
- ☐ Impacted Teeth
- ☐ Invisalign
- ☐ Pre-Prosthetic Alignment
- ☐ Temporo-Mandibular Disorder
- ☐ Other _____

- ☐ Crossbite/Functional Shift
- ☐ Crowding
- ☐ Growth/Skeletal Imbalance
- ☐ Minor Tooth Movement
- ☐ Missing Teeth
- ☐ Openbite
- ☐ Oral Habit/ Tongue Thrust

- ☐ Overbite
- ☐ Overjet
- ☐ Pre-Prosthetic Alignment
- ☐ Space Maintenance
- ☐ Spacing
- ☐ Speech Disorder
- ☐ Other _____

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

Comments:

_____

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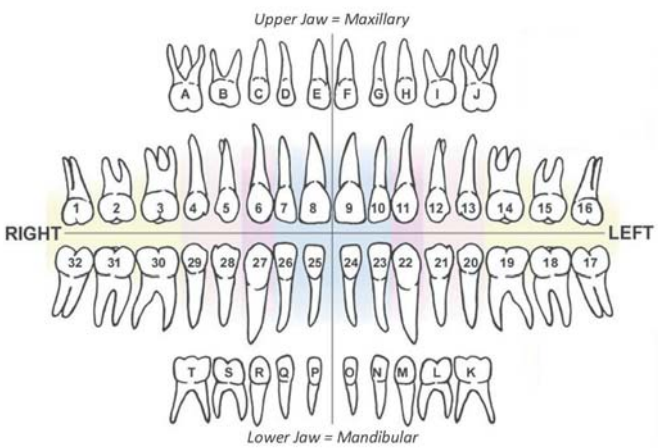

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