PATIENT REFERRAL CARD

Referring Doctor's Name:_____

Dental Office:_____

Doctor's Phone:_____ ☐ Office ☐ Cell ☐ Other

Doctor's e-mail:_____

Patient Information

Patient Name: _____

Date of Birth:____/____/____

Responsible Party: _____

Responsible Party Phone Number_____ ☐ Home ☐ Cell

What are your primary concerns regarding this patient (check all that apply)

☐ Class II	☐ Deep Bite	☐ TMD
☐ Class III	☐ Open Bite	☐ Impacted Teeth
☐ Crowding	☐ Excessive Overjet	☐ Missing Teeth
☐ Spacing	☐ Crossbite	☐ Other

Any additional dental problems? (check all that apply

☐ Oral Surgery ☐ Periodontal ☐ Endodontic ☐ Implants

Are any of the following radiographs available to be sent? (check all that apply)

☐ Periapicals ☐ Panoramic ☐ Bite Wing ☐ Full Mouth

Concerns and comments:_____

_____

_____

_____

Thank you for this referral. We will return to you, for your files, an "Examination Report" as soon as possible after seeing your patient.