VU Orthodontics

Creating Beautiful Smiles Through the Arts & Sciences of Orthodontics

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Patient will return to the referring doctor.

Date: _____

Patient: _____ Age: _____ Tel: _____

Referring Dr. _____ Tel: _____

Address: _____

Date of last dental check up: _____

Chief complaint: _____

Referral purpose(s):

☐ crowding ☐ impacted ☐ overbite ☐ overjet ☐ open bite ☐ crossbite

☐ uprighting ☐ closing space ☐ creating space ☐ intruding ☐ extruding

☐ CBCT (cone beam computed tomography) ☐ CBCT for implant(s)

☐ other _____

Dental procedure(s) to be completed: _____

_____

_____

Radiograph(s) sending: _____

Comments/instructions: _____

_____

_____

_____

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