VU Orthodontics

Creating Beautiful Smiles Through the Arts & Sciences of Orthodontics

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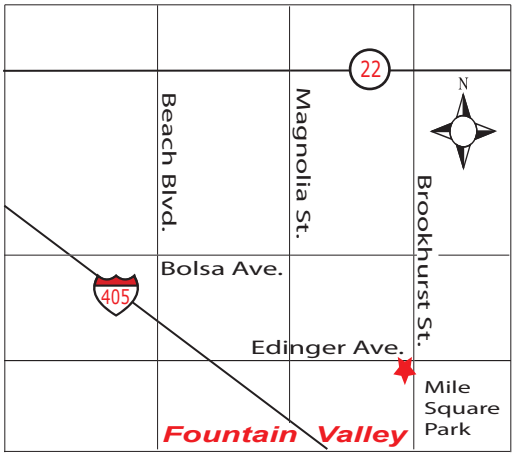
Patient will return to the referring doctor.

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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