Smith Family Orthodontics

ORTHODONTIC REFERRAL

529 Palace Road, Unit 1, Kingston ON K7L 4T6
Tel: (613) 544-4445 • Fax: (613) 544-4028
info@smithfamilyorthodontics.com

Patient: _____ D.O.B.: _____

Address: _____

Phone: _____ Sex: ❑ M ❑ F

Patient Cell Phone: _____ Email: _____

Account Cell Phone: _____ Email: _____

Referred for:
- ❑ general assessment
- ❑ specific assessment

Concerns expressed by:
- ❑ dentist
- ❑ patient/parent

Concerns regarding:
- ❑ esthetics
- ❑ function
- ❑ other _____

Orthodontic concerns discussed with patient:

DENTAL
- ❑ crowding
- ❑ spacing
- ❑ missing/impacted teeth
- ❑ overjet/dental protrusion
- ❑ deep bite
- ❑ open bite
- ❑ anterior crossbite
- ❑ posterior crossbite

SKELETAL
- ❑ mandibular retrognathism
- ❑ mandibular prognathism
- ❑ maxillary retrusion
- ❑ maxillary protrusion
- ❑ vertical maxillary excess

FUNCTIONAL
- ❑ habits
- ❑ TMJ dysfuction

Patient has had:
- ❑ scaling
- ❑ panoramic
- ❑ full mouth x-rays

Patient requires:
- ❑ scaling
- ❑ radiographs
- ❑ caries control
- ❑ referral to other specialist _____

Comments: _____

_____

_____

Dentist: _____ Date: _____

Signature: _____