



WILSON DENTAL

289 Chenango St.
Binghamton, NY 13901
(607) 217-7123 Fax (607) 238-1276

ORTHODONTIC REFERRAL

Date: _____

Introducing: _____

Daytime Telephone: _____

Patient has been referred for the following:

- | | |
|---|--|
| <input type="checkbox"/> General Orthodontic Evaluation | <input type="checkbox"/> Facial Growth Disorder |
| <input type="checkbox"/> Dentofacial Orthopedics | <input type="checkbox"/> Orthognathic Surgical Evaluation |
| <input type="checkbox"/> Temporo-Mandibular Disorder | <input type="checkbox"/> Early Interceptive Treatment |
| <input type="checkbox"/> Habit Correction Treatment | <input type="checkbox"/> Restorative / Prosthetic Concerns |
| <input type="checkbox"/> Minor Tooth Movement | <input type="checkbox"/> Adjunctive Orthodontics |

Patient has been referred for the following:

- | | |
|--|---|
| <input type="checkbox"/> Dental Crowding | <input type="checkbox"/> Crossbite |
| <input type="checkbox"/> Overjet | <input type="checkbox"/> Thumb/Finger Habit |
| <input type="checkbox"/> Dental Spacing | <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> Overbite | <input type="checkbox"/> Impacted Teeth |
| <input type="checkbox"/> Dentofacial Imbalance | <input type="checkbox"/> Ectopic Eruption |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Prosthetic Consideration |
| <input type="checkbox"/> Openbite | <input type="checkbox"/> Restorative Considerations |
| <input type="checkbox"/> Facial Esthetics | <input type="checkbox"/> Invisalign Treatment |

Radiographs:

- | | |
|---|---|
| Please Take: <input type="checkbox"/> Panoramic X-ray | <input type="checkbox"/> Cephalometric X-ray |
| <input type="checkbox"/> X-rays have been given to the patient | <input type="checkbox"/> Send a copy of the X-rays |
| <input type="checkbox"/> X-rays have been mailed to your office | |
| <input type="checkbox"/> Call before taking X-rays | <input type="checkbox"/> Please return X-rays to our office |

Remarks: _____

Referred By: _____

Signature: _____

Date: _____ Phone Number: _____