WILSON DENTAL

224 S. Geddes St.
Syracuse, NY 13204
(315) 423-9900 Fax (607) 238-1276

ORTHODONTIC REFERRAL

Date: ______________________________

Introducing: ______________________________

Daytime Telephone: ______________________________

Patient has been referred for the following:

- ____ General Orthodontic Evaluation
- ____ Dentofacial Orthopedics
- ____ Temporo-Mandibular Disorder
- ____ Habit Correction Treatment
- ____ Minor Tooth Movement
- ____ Facial Growth Disorder
- ____ Orthognathic Surgical Evaluation
- ____ Early Interceptive Treatment
- ____ Restorative / Prosthetic Concerns
- ____ Adjunctive Orthodontics

Patient has been referred for the following:

- ____ Dental Crowding
- ____ Overjet
- ____ Dental Spacing
- ____ Overbite
- ____ Dentofacial Imbalance
- ____ Missing Teeth
- ____ Openbite
- ____ Facial Esthetics
- ____ Crossbite
- ____ Thumb/Finger Habit
- ____ Speech Disorder
- ____ Impacted Teeth
- ____ Ectopic Eruption
- ____ Prosthetic Consideration
- ____ Restorative Considerations
- ____ Invisalign Treatment

Radiographs:

Please Take: ____ Panoramic X-ray ____ Cephalometric X-ray

- ____ X-rays have been given to the patient
- ____ Send a copy of the X-rays
- ____ X-rays have been mailed to your office
- ____ Call before taking X-rays
- ____ Please return X-rays to our office

Remarks: ______________________________

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Referred By: ______________________________

Signature: ______________________________

Date: ______________ Phone Number: ______________