

ORTHODONTIC REFERRAL FORM

Instructions for the Referring Dentist or Physician:

- 1) Please download this form.
- 2) Please complete the information, then, if convenient, either
 - Fax the form to our office – Please call us at (310) 247-8880 prior to faxing the information. **Our fax number is (310) 246-6691** OR
 - Email the form by clicking the Submit button.
- 3) Please provide the patient a copy and ask the patient or parent to contact our office for our complementary orthodontic evaluation appointment.
- 4) Patients are encouraged to visit our website to learn about Orthodontics and our services prior to their orthodontic visit.
- 5) Please retain a copy of this referral form in your patient records.

Thank you for the opportunity to serve your patients!

Jeffrey M. Cohen, DMD

TODAY'S DATE: _____

Introducing: _____

Patient's Telephone: _____

Referring Dentist/Physician:

Phone No.: _____

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

PATIENT'S CONCERNS:

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

RADIOGRAPHS:

Please take: Panoramic X-ray Cephalometric X-ray

- | | | |
|--|---|--|
| <input type="checkbox"/> X-rays have been given to the patient | <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 | <input type="checkbox"/> Send a copy of the x-rays |

SPECIAL INSTRUCTIONS OR REMARKS: