WILSON DENTAL

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

ORTHODONTIC REFERRAL

Date: _____

Introducing: _____

Daytime Telephone: _____

Referred By: _____

Phone No.: _____

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

Remarks:

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