Patient Information

Patient Name _____ Age Sex

Patient Phone Number _____ May we call this patient to schedule an appointment? ☐ Yes ☑ No

Referring Doctor _____ Last Visit _____

Doctor's Email _____ Office Phone Number _____

Primary Concerns _____

Medical Information

Concerns:

- ☐ Class **II**
- ☐ Class **III**
- ☐ Deep Bite
- ☐ Open Bite
- ☐ Excessive Overjet
- ☐ Crossbite
- ☐ Crowding
- ☐ TMD
- ☐ Impacted Teeth
- ☐ Missing Teeth

Other: _____

Specific Dental Problems:

- ☐ Oral Surgery
- ☐ Periodontal
- ☐ Endodontic
- ☐ Implants

Radiographs Available:

- ☐ Periapicals
- ☐ Panoramic
- ☐ Bite Wing
- ☐ Full Mouth Series

Addition Information:

Refer Patient