

## COMPLIMENTARY CONSULTATION

Introducing \_\_\_\_\_ DOB \_\_\_\_\_

Consultation Date and Time \_\_\_\_\_

Referring Dr. \_\_\_\_\_ Date \_\_\_\_\_

### This patient is being referred for:

- |   |  |
|---|--|
| <input type="checkbox"/> General Orthodontic Evaluation | <input type="checkbox"/> Impacted Teeth _____                      |
| <input type="checkbox"/> Class 2 / Class 3 (circle)     | <input type="checkbox"/> Missing Teeth _____                       |
| <input type="checkbox"/> Crowding / Spacing (circle)    | <input type="checkbox"/> Pre-Prosthetic / Implant Site Development |
| <input type="checkbox"/> Overbite / Overjet (circle)    | <input type="checkbox"/> Lingual / Clear Braces (circle)           |
| <input type="checkbox"/> Crossbite                      | <input type="checkbox"/> Invisalign®                               |
| <input type="checkbox"/> Openbite                       | <input type="checkbox"/> Space Maintainer                          |

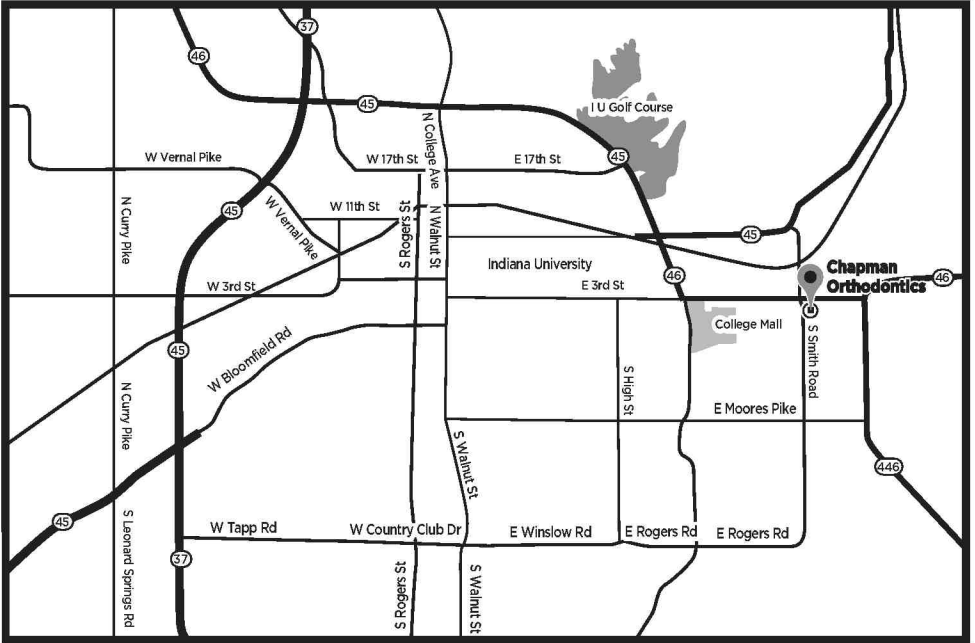
### Restorative Treatment:

- is completed     is underway     is pending outcome of orthodontic findings
- Recent full mouth/panoramic radiographs are available                      Date \_\_\_\_\_

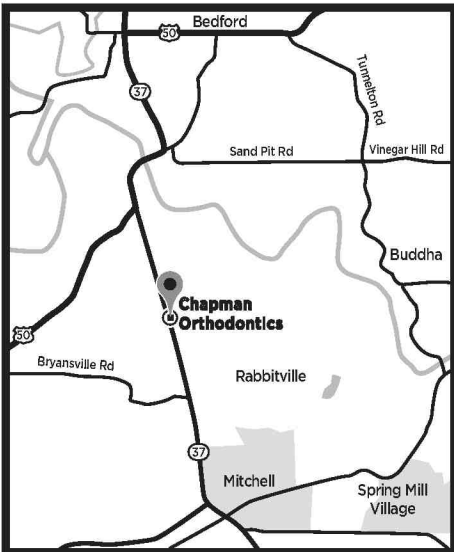
### Comments:

\_\_\_\_\_  
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# BLOOMINGTON OFFICE



# MITCHELL OFFICE



# MARTINSVILLE OFFICE

