MARIN BRACES
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DOCTOR INFORMATION

REFERRING DOCTOR'S NAME: _____ PRACTICE NAME:_____

DOCTOR'S PHONE: _____ OFFICE ☐ CELL ☐ OTHER ☐

DOCTOR'S EMAIL:_____

IS IT OKAY TO CALL WITH QUESTIONS? YES ☐ NO ☐

PATIENT INFORMATION

PATIENT'S NAME: _____ MALE: ☐ FEMALE: ☐ D.O.B: _____

IS IT OKAY TO CALL THE PATIENT TO SCHEDULE AN APPOINTMENT: YES ☐ NO ☐

PATIENT' S PHONE: _____ OFFICE ☐ CELL ☐ OTHER ☐

WHAT ARE YOUR SPECIFIC CONCERNS REGARDING THIS PATIENT? PLEASE CHECK ALL THAT APPLY.

CLASS II ☐	EXCESSIVE OVERJET ☐	OTHER ☐
CLASS III ☐	CROWDING ☐	_____
DEEP BITE ☐	TMD ☐	_____
OPEN BITE ☐	IMPACTED TEETH ☐	_____
CROSS BITE ☐	MISSING TEETH ☐	_____

ANY ADDITIONAL DENTAL PROBLEMS? PLEASE CHECK ALL THAT APPLY.

☐ORAL SURGERY ☐PERIODONTAL ☐ENDODONTIC ☐IMPLANTS

ANY OF THE FOLLOWING RADIOGRAPHS AVAILABLE TO BE SENT? PLEASE CHECK ALL THAT APPLY.

☐PERIAPICALS ☐PANORAMIC ☐BITE WING ☐FULL MOUTH

IN TERMS OF ORAL HYGIENE AND/OR PERIODONTAL HEALTH, IS THE PATIENT CLEARED TO PROCEED WITH ORTHODONTIC TREATMENT?

YES ☐ NO ☐

PLEASE PROVIDE ANY ADDITIONAL INFORMATION YOU WANT US TO KNOW.

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