CARUS orthodontics

A Lifetime of Smiles.

ORTHODONTIC REFERRAL

PATIENT NAME	DOB	PHONE
PARENT/GUARDIAN (MINORS)	REFERRED BY	OFFICE
RECENT X-RAYS SENT ☐ PA'S ☐ PANOREX ☐ NONE		REFERRAL DATE

REASON FOR REFERRAL- COMPLETED BY GENERAL DENTIST

☐ General Orthodontic Evaluation

☐ Specific Concern (please check all that apply):

☐ Class I Malocc ☐ Crossbite(s) ☐ Openbite ☐ Impaction(s): _____

☐ Class II Malocc/Div 1 ☐ Space Maintenance ☐ Crowding ☐ Missing Teeth: _____

☐ Class II/Malocc/Div 2 ☐ Excess Overjet ☐ Spacing ☐ Tongue/Thumb/Finger Habit

☐ Class III Malocc ☐ Excess Overbite

☐ Additional Concerns:

Patient/Parent are concerned with problem (please check): ☐ Yes ☐ No ☐ Somewhat

Dentist Signature: _____

CARUS ORTHODONTICS LOCATIONS

☐ **Atascocita**
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281.446.2153
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