GREGORY A. LAMANSKY, DDS
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ASSOCIATED ORTHODONTISTS

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Orthodontic referral

Date:____________________ Referring DDS:_______________________

Introducing: _________________________________ patient BD: _______________________

Pt. responsible party:_________________________________ phone:____________________

Recent panorex: _______________________________________date:_____________________

Reason for referral: ____

____

General orthodontic evaluation: ____

Specific Concern (please check):

Class II: ___________________ Class III: ______________________

Crossbite(s): _______________ Space maintenance: ___________

Tongue/Finger/Thumb habit: ____

Impaction(s): ________________ Missing teeth: __________________

Additional Concern (s) : ____

____

Parent/Patient concerned about this? Yes ________________ No ________________

____

referring Doctor's signature

Clinic Address: ____

Phone number: ___________________________