Lauren S. Busch, DDS, MS
Orthodontist

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ORTHODONTIC REFERRAL

Date:___________________________

Patient Name:____ DOB: _________________________

Daytime Telephone: ____

Would you prefer Dr. Lauren Busch's office to contact patient? ___ Yes ___ No

Patient has been referred for the following:

___General Orthodontic Evaluation
___Dentofacial Orthopedics
___Habit Correction Treatment
___Minor Tooth Movement
___Dental Crowding
___Overjet
___Dental Spacing
___Overbite
___Missing Teeth
___Openbite
___Orthognathic Surgical Evaluation
___Early Interceptive Treatment
___Restorative / Prosthetic Concerns
___Adjunctive Orthodontics
___Crossbite
___Thumb / Finger Habit
___Impacted Teeth
___Ectopic Eruption
___Prosthetic Consideration
___Restorative Considerations
___Invisalign Treatment

Radiographs:

___**Please Take:** ___Panoramic X-ray
___X-rays have been given to the patient
___X-rays have been mailed to your office
___Call before taking X-rays
___Cephalometric X-ray
___Send a copy of the X-rays
___Please return X-rays to our office

Reason for Referral: ____

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Referred By: ____

Signature: ____

Date: ________________ Phone Number: ________________________ Email: ________________________________