Ferris Orthdontics Doctor Referral Form

Patient Information

Patient Name: _____

Patient Phone Number: _____

May we call this patient to schedule an appointment?

- ☐ Yes
- ☐ No

Age: _____ Sex: _____

Referring Doctor: _____ Office Phone Number: _____

Last Visit: _____

Doctor's E-mail: _____

Primary Concerns: _____

_____

_____

Medical Information

Concerns:

- ☐ Class I
- ☐ Class III
- ☐ Deep Bite
- ☐ Excessive Overjet
- ☐ Crossbite
- ☐ Crowding
- ☐ TMD
- ☐ Impacted Teeth
- ☐ Missing Teeth

Other:

_____

_____

Specific Dental Problems:

- ☐ Oral Surgery
- ☐ Peridontal
- ☐ Endontic
- ☐ Implants

Radiographs Available:

- ☐ Periapicals
- ☐ Panoramic
- ☐ Bite Wing
- ☐ Full Mouth Series

Additional Information:

Submit