AbrahamOrthodontics

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Specialist in Orthodontics & Dentofacial Orthopedics
185 Erie St. S Leamington ON N8H3B9
www.AbrahamOrthodontics.com

REFERRAL FORM

Date: ______ **Referring Office:** ______

Dentist or Hygienist: ______ **Staff Member:** ______

PATIENT INFORMATION

Patient's Name: ______ ______ ______
Last First Middle

DOB ______

Patient's Guardian ______ ______ ______
Last First Relationship

______ ______ ______
Home Phone Other Phone Email

FOR THE ORTHODONTIC EVALUATION FOR:

- ☐ **Crowding**
- ☐ **Spacing**
- ☐ **Premature Loss of Tooth**
- ☐ **Pre- Restorative**
- ☐ **Missing Teeth**
- ☐ **Impacted Teeth**
- ☐ **Overjet**
- ☐ **Facial Growth**
- ☐ **Oral Habit**
- ☐ **Other (Specify Below)**
- ☐ **Cross Bite**
- ☐ **Under Bite**
- ☐ **Deep Bite**
- ☐ **Open Bite**

Comments:

______

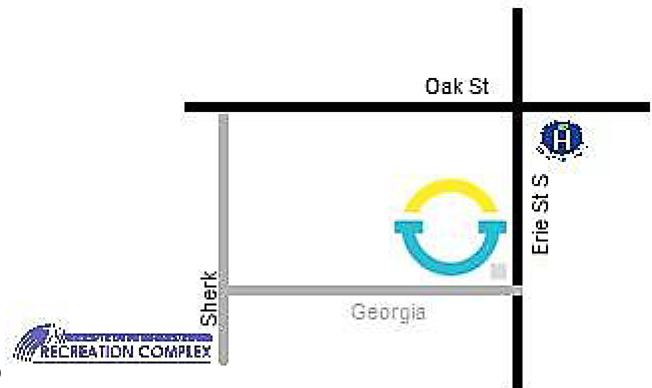
Is the patient undergoing active dental treatment? ☐No ☐Yes ______

Periodontal Records current (Adults)? ☐ Yes ☐No (Please Update and send)

Panoramic X-Ray: ☐With Patient ☐Emailed to: Info@AbrahamOrthodontics.com

Patient: ☐Expecting Call ☐Will Call

Located on Erie St S. at Georgia Ave, near Oak. Call For An Appointment Today!



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