Embrace
ORTHODONTICS
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ORTHODONTIC REFERRAL

Date: _____ Patient Name: _____ Date of Birth: _____

Treay #: _____ Sask. Health #: _____ Social Worker Name: _____

Complete Mailing Address: _____

_____

PARENT/GUARDIAN INFORMATION:

Mother: _____ Father: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Email: _____ Email: _____

Resides with: ❑ Mother ❑ Father ❑ Both ❑ Other: _____

REFERRED FOR:

- ❑ General Orthodontic Evaluation
- ❑ Early Interceptive Treatment
- ❑ Clear Aligner Consultation
- ❑ Orthognathic Surgery Evaluation
- ❑ Pre-Prosthetic/Pre-Implant Treatment
- ❑ TMJ Disorder
- ❑ Other: _____

AREAS OF CONCERN:

- ❑ Crowding
- ❑ Impacted Tooth
- ❑ Spacing
- ❑ Overjet
- ❑ Overbite
- ❑ Cross bite

Comments: _____

_____

_____

Please ensure oral hygiene is adequate prior to referring patients for orthodontic treatment

This patient attended our office _____. He/She demonstrated GOOD | FAIR | POOR (circle one) oral hygiene.

If good or fair, has all restorative treatment been completed and is the patient caries free? ❑ YES ❑ NO

❑ Immediate family members receiving (or received) treatment at our office: _____

Referred by: _____ Phone: _____ X-Rays Included: ❑ YES ❑ NO

Dentist / Dental Therapist Signature: _____