ONSHORE
ORTHODONTICS

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INTRODUCING: _____ APPOINTMENT DATE & TIME: _____

DATE: _____ REFERRING DR. : _____ PHONE: _____

Please call to schedule your patient's appointment. Patient referrals can also be done through our website.

Type of Treatment Needed:

- ☐ General Orthodontics Evaluation
- ☐ Adjunctive Orthodontics
- ☐ Clear Braces
- ☐ Dentofacial Orthopedics
- ☐ Early Interceptive Treatment
- ☐ Facial Growth Anomaly
- ☐ Habit Correction Treatment
- ☐ Invisalign
- ☐ Lingual Orthodontics
- ☐ Orthognathic Surgical Evaluation
- ☐ Pre-Prosthetic/Implant Site Development
- ☐ Other: _____

Dental Problems:

- ☐ Crossbite/Functional Shift
- ☐ Growth/Skeletal Imbalance
- ☐ Impacted Teeth
- ☐ Missing Teeth
- ☐ Openbite
- ☐ Oral Habit/Tongue Thrust
- ☐ Overbite
- ☐ Overjet
- ☐ Space Maintenance
- ☐ Crowding
- ☐ Spacing
- ☐ Other: _____

Comments: _____

☐ Please call me before proceeding ☐ I have sent radiographs for your evaluation.

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.