KAMLESH G. PATEL, DMD
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(301)879-9500

visit our smile gallery
www.PatelOrthodontics.com

ORTHODONTIC REFERRAL FORM

Instructions for the Referring Dentist or Physician:

1) Please download this form.
2) Please complete the information, then, if convenient, either
   - Fax the form to our office – Please call us at (301)879-9500 prior to faxing the information OR
   - Mail the form to our office at the above address.
3) Please provide the patient a copy and ask the patient or parent to contact our office for our complementary orthodontic evaluation appointment.
4) Patients are encouraged to visit our website to learn about Orthodontics and our services prior to their orthodontic visit.
5) Please retain a copy of this referral form in your patient records.

Thank you for the opportunity to serve your patients!

Kamlesh G. Patel, D.M.D.

TODAY'S DATE: _____

Introducing: _____ **Patient's Telephone:** _____

Referring Dentist/Physician:

_____
_____
_____
_____
_____
Phone No.: _____

PATIENT HAS BEEN REFERRED FOR THE FOLLOWING:

- ❑ General Orthodontic Evaluation
- ❑ Facial Growth Disorder
- ❑ Dentofacial Orthopedics
- ❑ Temporo-Mandibular Disorder
- ❑ Early Interceptive Treatment
- ❑ Orthognathic Surgical Evaluation
- ❑ Habit Correction Treatment
- ❑ Restorative / Prosthetic Concerns
- ❑ Minor Tooth Movement
- ❑ Adjunctive Orthodontics

PATIENT'S CONCERNS:

- ❑ Dental Crowding
- ❑ Overjet
- ❑ Dental Spacing
- ❑ Overbite
- ❑ Dentofacial Imbalance
- ❑ Openbite
- ❑ Facial Esthetics
- ❑ Crossbite
- ❑ Thumb/Finger Habit
- ❑ Missing Teeth
- ❑ Speech Disorder
- ❑ Impacted Teeth
- ❑ Ectopic Eruption
- ❑ Prosthetic Considerations
- ❑ Restorative Considerations
- ❑ Invisalign Treatment

RADIOGRAPHS:

Please take:

- ❑ Panoramic X-ray
- ❑ Cephalometric X-ray
- ❑ X-rays have been given to the patient
- ❑ X-rays have been mailed to your office
- ❑ Call before taking x-rays
- ❑ Please return x-rays to our office
- ❑ Send a copy of the x-rays

SPECIAL INSTRUCTIONS OR REMARKS:

_____
_____
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