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*Orthodontics and Dentofacial Orthopedics
Adults and Children*

Member
American Association of
Orthodontists



Date: _____

Referring Doctor: _____ **Phone:** _____

Patient Name: _____

Please evaluate:

Orthodontics TMJ Other_____

Restorative & periodontal status:

Complete / Stable Incomplete / Active Disease

Desired recall interval:

3 months 4 months ___ months

Recent radiographs available for our review:

Full mouth series Panorex Cephalometric
 Bitewings Occlusal Other_____

Comments: _____

Please send additional referral slips.

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