Welch Orthodontics

Doctor Referral Form

Referring Doctor ______________________________

Phone Number ______________________________

Patient Name ______________________________

Date of Birth ______ ______ ________
MM DD YYYY

Contact patient to schedule appointment via:

Parent or Guardian: ______________________________

Cell Number: ________________ Home Phone: ________________

Email Address: ______________________________

This patient is being referred for the evaluation of the following:

- ❑ General Orthodontic Evaluation
- ❑ Invisalign
- ❑ Early Interceptive Treatment
- ❑ Impact Site
- ❑ Pre-Prosthetic Development
- ❑ Pontic Site
- ❑ Orthognathic Surgical Evaluation

Other, please specify: ______________________________

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Panoramic X-Ray: ❑ Sent with patient ❑ Take at evaluation appointment

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