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ASSOCIATED ORTHODONTISTS, SC

Member American Association of Orthodontists

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Wausau, WI 54401
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Date: ______________ Referring Doctor: ______________________

Introducing: ____

Pt. Phone: ____

Recent X-rays: Periapical: __________ Panorex: __________

Reason for Referral: ______________________________________

____

General Orthodontic Evaluation: ______________________

Specific Concern (please √)

Class II: __________ Class III: __________

Crossbite(s): __________ Space Maintenance: __________

Tongue/Finger/Thumb Habit: __________

Impaction(s): __________ Missing Teeth: __________

Additional Concern(s): ____________________________________

____

Patient/Parent concerned about this? Yes ❑ No ❑

____
Referring Doctor's Signature

Appointment: ____

Need more forms? __________

AO-45, 5.08

White - Orthodontist Copy Yellow - Referring Doctor Pink - Patient Copy