Bellevue Dentist

Orthodontic Referral Form

Patient's Name: _____ DOB: _____

Guardian's name: _____ Phone: _____

Patient's Contact Info: _____ Date: _____

Referring Doctor: _____ Dr's Office Phone: _____

Reason for Referral:

_____

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The referring office will send the diagnostic information below:

- ☐ Radiographs
- ☐ CBCT scan (.dicom)
- ☐ Intraoral scan (.stl/.ply)
- ☐ Clinical Pictures
- ☐ Models
- ☐ Periodontal Charting

Does the patient have restorative and periodontic clearance to start orthodontic treatment? (If not, please explain.)

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Thank you for your referral. We will get back to you with the Orthodontic evaluation progress.

Address: 14645 Bel-Red Rd, Suite 100, Bellevue, WA 98007
www.bellevuedentist.com | Info@bellevuedentist.com | Call/Txt: (425) 644-2205 | Fax: (425) 644-1564