SMILES

AUSTIN | DRIPPING SPRINGS

Orthodontics and Pediatric Dentistry

Scott Franklin, DDS
Tim Brunson, DDS, MS
Carrie Lindsey, DDS, MS
Aaron Collins, DDS
Tiffany Barrett, DDS

www.smilesofaustin.net

Patient's Name: _____

Patient's Date of Birth: _____

Parent / Guardian's Name (if applicable): _____

Contact Phone Number & Email: _____

Referring Doctor / Practice: _____

Reason for Referral: _____

For Orthodontic Treatment

- ☐ Crowding
- ☐ Excessive Overjet
- ☐ Missing Tooth / Teeth
- ☐ Unerupted Tooth / Teeth
- ☐ Habit
- ☐ Deep Overbite
- ☐ Posterior Crossbite
- ☐ Anterior Crossbite
- ☐ Open Bite
- ☐ TMJ
- ☐ Other - Explain: _____

For Pediatric Dental Treatment

☐ Recommended Treatment: _____

_____

☐ X- Rays Taken: _____

☐ Comments: _____