

SMILES

AUSTIN | DRIPPING SPRINGS

Orthodontics and Pediatric Dentistry

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www.smilesdfaustin.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

☐ Unerrupted Tooth / Teeth

☐ Habit

☐ Other - Explain: _____

☐ Deep Overbite

☐ Posterior Crossbite

☐ Anterior Crossbite

☐ Open Bite

☐ TMJ

For Pediatric Dental Treatment

☐ Recommended Treatment: _____

☐ X- Rays Taken: _____

☐ Comments: _____

Austin

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