LA DENTAL BRACES
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1127 Wilshire Blvd Suite 404
Los Angeles CA 90017
(323) 600-5287

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ORTHODONTIC REFERRAL FORM

Date:	
Referring Office:	
Dentist / Hygienist / Staff Name:	

Patient Name: _____
First Middle Last

Date of Birth: _____

Cell Phone Number: _____ Other Phone: _____

Email Address: _____

The patient is being referred for:	***Clinical Findings:***	
☐ General Orthodontic Evaluation	☐ Airway/breathing concerns	☐ Overbite
☐ Early Interceptive Treatment	☐ Missing teeth	☐ Overjet
☐ Invisalign consultation	☐ Class II	☐ Crowding
☐ Orthognathic Surgery Evaluation	☐ Openbite	☐ Spacing
☐ Pre-prosthetic/Pre-Implant Treatment	☐ Class III	☐ Space maintenance
☐ TMJ Disorder Evaluation	☐ Crossbite/functional shift	☐ Impacted teeth
	☐ Growth/skeletal imbalance	☐ Speech concerns
	☐ General procedure (cleaning, cavity, etc)	☐ Other

Comments:

_____

_____

_____

_____

Panoramic Radiograph (check all that apply):

☐ Emailed to manager@ladentalbraces.us ☐ Sent to Patient ☐ Not Available

We provide virtual consultation on our website.