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Orthodontic Referral

Patient's Details:

Name:_____

Address:_____

DOB:_____ **Phone:**_____

Referral Details (please tick)

□ ***Top teeth stick out***

□ ***Bottom teeth stick out***

□ ***Crowded top teeth***

□ ***Crowded bottom teeth***

□ ***Traumatic bite***

□ ***Thumbsucker***

□ ***Other:***

□ ***Anterior open bite***

□***Posterior open bite***

□ ***Missing teeth***

□ ***Unerupted teeth***

□ ***Anterior crossbite***

□ ***Posterior crossbite***

Teeth of questionable prognosis:_____

_____

Notes: _____

_____

Referred by:_____