WISE LEE
ORTHODONTICS
"Great Smiles . . . Built To Last!"
WiseLeeOrtho.com
972-712-6862

Orthodontic Evaluation Referral Form

Please fax to Wise-Lee Orthodontics: 972-377-9559

Or email to info@wiseleeortho.com

Patient's Name____ **Today's Date**_______________________

Patient's Date of Birth__________________________ **Circle:** Male or Female

Contact Info (parent name, cell #) ____

Dental Status: (circle all that apply)

all dental care up to date needs cleaning needs sealants needs restorations

Next visit in your office/Date:____________________ Procedure planned______________________________

Note: ____

Oral Hygiene: excellent good fair poor Needs OH check prior to ortho commencing

Note: ____

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Orthodontic Concern: (circle all that apply) crowding OB OJ screening only narrow palate frenum spacing missing/extra teeth (specify) ______________ sleep disturbances Class 3 (underbite) habit

X-rays Sent(info@wiseleeortho.com): ____

Additional Notes: ____

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☐ Check the box if you would like to communicate with Dr. Lee or Dr. Wise about this patient prior to their arrival.

Doctor Name:_____________________________________ **Date:**_______________________________________