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: _____

_____

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: _____

_____

_____

_____

_____

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

Doctor Name:_____ **Date:**_____