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Orthodontic Referral

Patient Name________________________________ Age ______________________________

Phone: ____________________ Parent's Name: ______________________________________

Special Health Concerns:____

Patient Insurance Information: ____

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	☐ Open Bite	☐ Spacing
☐ Pre-prosthetic / Pre-implant Treatment	☐ Class III	☐ Space Maintenance
☐ TMJ Disorder Evaluation	☐ Crossbite/ functional shift	☐ Impacted teeth
	☐Growth/ skeletal imbalance	☐ Speech concerns
	☐ Other	

Notes:____

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Referring Doctor information:

☐ X-rays Given to Patient ☐ X-rays mailed/E-mailed ☐ Needs X-rays

Referring Doctor: Kevin S. Welinsky DDS Phone: 410-321-8480

Email address: wdctowson@gmail.com Date: ______________________________