ShoreSmiles
ORTHODONTICS

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PLEASE FAX OR EMAIL THIS FORM

PATIENT INFORMATION

DATE OF REFERRAL _____

Patient's Name (first middle last)	Birth Date (MM/DD/YYYY)	Sex ☐ Male ☐ Female
Parent or Legal Guardian Name (first middle last)		
Address	City	State / ZIP
Phone ☐ cell ☐ home ☐ work	Email	
Insurance & Plan Name (attach copy of insurance card)		
Name, Relationship & DOB of Primary Insured (if not patient)		

DISCUSS & EVALUATE

- ☐ Early diagnosis and Prevention
- ☐ Braces:
  - ☐ Traditional ☐ Invisalign ☐ Other
- ☐ Extraction
- ☐ Wisdom teeth removal
- ☐ Dental implants
- ☐ Space Maintenance
- ☐ Habit
- ☐ Cross-bite
- ☐ Crowding/spacing
- ☐ Open bite/deep bite
- ☐ Over jet
- ☐ Impaction
- ☐ Other:

Notes:

Please email available records and dental radiographs to info@shoresmilesortho.com

REFERRING PROVIDER INFORMATION

Referring Provider's Name	Cell (for emergencies)
Referring Provider's Email	
Practice Name and Address	Fax
Referral Coordinator Contact Name & Email	Phone
How would you like for us to send you Progress Notes? ☐ By Fax ☐ By Mail ☐ By Email (HIPAA compliant):	

www.ShoreSmilesOrtho.com
Thank you for your referral!