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Member
American Association of
Orthodontists®

REFERRAL FOR DENTAL TREATMENT

Dear Doctor

Please perform the treatment check-marked below for our mutual patient:_____.
Or, if treatment was completed recently, then please indicate the date(s) of service on the lines on the bottom portion of this page.
Please email this referral back to our office upon receipt. Please feel free to call me anytime if there are any questions. Thank you.

_√___ No BRIDGES nor IMPLANTS until after orthodontics.

__x__ Prophylaxis (Dental Cleaning): Scaling & Polishing.

_____ Periodontal Evaluation and Treatment – Full Mouth Perio Probing & Charting, Quadrant Anesthesia and Quadrant Deep Scaling. Please FAX a copy of the Probing Depths.

_____ If the above Periodontal Care is not sufficient, then please refer this patient out to a PERIODONTIST *(See #3 BELOW).*

__x__ Caries Check: Complete <u>all</u> necessary restorations…

<u>ESPECIALLY</u> on the following teeth: _____

<u>EXCEPT</u> on the following teeth: _____

_____ Permanent Restorations are preferred

_____ Temporary Restorations are preferred

_____ Other Procedures:_____

_____

_____

_____

_____

Thank you, and we look forward to working together with you.

Orthodontist's Signature:_____ Today's Date: _____

TO BE COMPLETED BY THE DENTIST:

1) I certify that the following treatment HAS BEEN rendered:_____

_____

_____

2) Comments & / Or Additional Treatment Needed: _____

_____

_____

3) I certify that this patient's periodontal and dental treatment have been performed & the patient is ready to begin or continue orthodontic treatment.

_____	_____	_____
Date of Treatment	Treating Doctor's Signature	Treating Doctor's Printed Name

Dentist's Telephone # _____

Please email back to oaksortho@sbcglobal.net