Dr. Curtis Contro's Referral Form

Welcome! Thank you for entrusting your patient's orthodontic care to us. We pride ourselves in giving the highest quality of care that is tailored to each patient's unique needs and circumstances. Please fill out the following information and we will reach out to your patient as soon as possible to schedule an initial exam.

Referring Dentist's Name *

First Name Last Name

Dentist's Office Email (to receive confirmation) *

example@example.com

Patient's Name *

First Name Last Name

Name of Contact if not the same as the patient (ie Parent)

First Name Last Name

Patient's/Guardian's Phone Number *

Area Code Phone Number

Patient's/Guardian's Email *

example@example.com

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Desired Location *

Patient's chief concern *

Areas of Concern to the dentist *

- Crowding
- Spacing
- Class II
- Class III
- Deep Bite
- Open Bite
- Posterior Crossbite
- Anterior Crossbite
- Finger Habit
- Tongue Thrust
- TMD
- Need space idealized for a restoration

Dentist's treatment goals *

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