ORTHODONTICS

www.truorthodontics.ca

Dr. Mike Wagner
B.Sc. D.M.D. M.Cl.D. FRCD(C) - Certified Orthodontic Specialist

Referring doctor ______________________ **Date** ____________ MM/DD/YYYY

Patient name ______________________ **DOB** ____________ MM/DD/YYYY

Parent/guardian ______________________________________

Primary phone ____________ **Alternate phone** ____________

Reason for referral (please check all that apply)

- ☐ Crowding
- ☐ Crossbite
- ☐ Overbite
- ☐ Eruption concerns
- ☐ Growth concerns
- ☐ Overjet
- ☐ Spacing
- ☐ Missing teeth
- ☐ TMJ issues
- ☐ Impacted/Stuck teeth
- ☐ Extra teeth
- ☐ Early tooth loss
- ☐ Habit breaking
- ☐ Open bite
- ☐ Pre-prosthetic alignment

Other (please specify)

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Additional comments

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☐ Send more referral pads

Electronic version also available on our website

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Toll Free Fax: (877) 287-1127

Email: referral@truorthodontics.ca

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