



**Dr. Nadia Nizam**  
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## PATIENT REFERRAL

Referring Dentist: \_\_\_\_\_

Date: \_\_\_\_\_

Referring Dentist Phone #: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_

Gender:  Male  Female

Date of Birth: \_\_\_\_\_  
(month/day/year)

Home 📞 #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Other 📞 #: \_\_\_\_\_

### Referral Details

- Reason for Referral:
- Crowding/Spacing
  - Class 2 Malocclusion
  - Class 3 Malocclusion
  - Excessive overbite/overjet
  - Impacted/Missing teeth # \_\_\_\_\_
  - Crossbite \_\_\_\_\_
  - Cosmetic
  - 2<sup>nd</sup> Opinion
  - Other \_\_\_\_\_

- Radiographs are:
- Enclosed (keep/return)
  - With patient
  - Mailed separately
  - No radiographs
  - Emailed

- Restorative work is:
- Completed
  - Pending
  - Required post orthodontic treatment

### Appointment Details

- Please contact patient directly @ \_\_\_\_\_
- Patient will contact Impressions Orthodontics

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_