Orthodontic Referral

Patient:_____

Age:_____ DOB:_____

- ☐ Crooked teeth_____
- ☐ Crowding - Upper / Lower_____
- ☐ Spacing - Upper / Lower_____
- ☐ Crossbite - Anterior / Posterior_____
- ☐ Vertical - Deep bite / Open bite_____
- ☐ Overjet - Excess / Negative_____
- ☐ Habit - Thumb / Tongue thrust / Lower lip / Other_____
- ☐ Impaction_____
- ☐ Missing teeth_____
- ☐ Other_____

Notes:_____

_____

_____

_____

_____ _____

Referring Doctor Date

_____ _____

Signature Phone

Dr. Timothy A. Kuhlman
Kennedy Dental Care

6200 Saratoga Blvd. · Corpus Christi, Texas 78414
13725 Northwest Blvd., Ste. 270 · Corpus Christi, Texas 78410
(361) 992-9500 · info@kennedydentaltx.com · www.paulkennedydds.com

Dental Referral

To:

KENNEDY DENTAL CARE

PEDIATRIC DENTISTRY, ORTHODONTICS AND ORAL SURGERY

Patient: _____

Age: _____ DOB: _____

Date: _____

Reason for Visit: _____

_____

_____

_____

INDICATE TOOTH CONCERNS:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
				A	B	C	D	E	F	G	H	I	J			
R																L
				T	S	R	Q	P	O	N	M	L	K			
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

_____ _____

Referring Doctor Date

_____ _____

Signature Phone

6200 Saratoga Blvd. · Corpus Christi, Texas 78414
3435 S. Alameda #A · Corpus Christi, Texas 78411
13725 Northwest Blvd., Ste. 270 · Corpus Christi, Texas 78410
5525 S. Staples, Ste. A4 · Corpus Christi, Texas 78411
info@kennedydentaltx.com · www.paulkennedydds.com
361-992-9500