fusion
Orthodontics & Children's Dentistry

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ORTHODONTICS FOR ALL
DENTISTRY **FOR CHILDREN**

Date: _____

REFERRAL FORM

Please Email this form to **manager@fusiondentalclinic.com** or Fax to **(972) 666-4944**
To schedule your appointment, please visit **www.FusionDentalClinic.com** or call **(972) 666-4949**

Referring Doctor

Doctor´s Name: _____

Office Phone: _____

Web site: _____

Patient Information

Name: _____

Date of Birth: _____

Cell Phone: _____

Email: _____

Reason for Referral (Mark all that apply):

☐ **Perform Dental Treatment:** _____

Reason: ☐Combative ☐Acute Dental Phobia ☐Too young to cooperate ☐Medically/Physically Challenged

☐ **Perform Orthodontic Treatment**

☐ **Orthodontic Treatment Plan Only (I am going to treat myself)**

☐ **Limited Pre-Prosthetic Orthodontics:**

- ☐ Orthodontic Crown Lengthening: _____
- ☐ Space Distribution (for Veneers): _____
- ☐ Dental Intrusion/Dental Extrusion: _____

☐ **CBCT scan:** ☐Maxilla ☐Mandible ☐Both Jaws ☐Implant/Region: _____

Additional Comments:

_____

_____

_____

_____

Attached Records: ☐ None ☐ X-rays ☐ Photos ☐ Emailed ☐ Enclosed