

ORTHODONTIST INFORMATION

Name: _____ Phone: _____

Address: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Insurance Company: _____ Group Number: _____

PATIENT DENTAL HISTORY

Date of Most Recent Periapical and Bitewing Radiographs of Area: _____

Date of Most Recent Bitewing Radiographs: _____

Date of Most Recent Full Mouth Series of Radiographs: _____

Date of Most Recent Panoramic Radiograph: _____

Radiographs have been: e-mailed to your office mailed to your office sent with the patient

REASON FOR REFERRAL

Please evaluate the patient for:

Early or Interceptive Orthodontic Treatment

Full Orthodontic Treatment

Craniofacial Orthopedics

Pre-Prosthetic Treatment

Orthognathic Surgery

Other: _____

APPOINTMENT INFORMATION

- An appointment has been scheduled with your office on _____ at _____ .
- An appointment was unable to be made, but the patient will be contacting your office to schedule an appointment.
- Please contact this patient for an appointment.

Thank you for providing our patient with excellent care.

If you need any additional information or would like to speak to Dr. Dillner regarding this patient, please contact our office at 620.327.2887.

Thank you for keeping us updated on the patient's progress. Please send any treatment progress reports to: Hesston Dentistry, P.O. Box 250, Hesston, KS 67062 or via e-mail at office@hesstondentistry.com.

Sincerely,

Dr. Justin R. Dillner and the Hesston Dentistry Team