SMILES

AUSTIN | DRIPPING SPRINGS

Orthodontics and Pediatric Dentistry

Scott Franklin, DDS
Tim Brunson, DDS, MS
Carrie Lindsey, DDS, MS
Aaron Collins, DDS
Traci Simons, DDS, MS
Inna Burnett, DMD

www.smilesofaustin.net

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Parent / Guardian's Name (if applicable): ______________________________

Contact Phone Number & Email: ______________________________

Referring Doctor / Practice: ______________________________

Reason for Referral: ______________________________

For Orthodontic Treatment

- ☐ Crowding
- ☐ Excessive Overjet
- ☐ Missing Tooth / Teeth
- ☐ Unerupted Tooth / Teeth
- ☐ Habit
- ☐ Deep Overbite
- ☐ Posterior Crossbite
- ☐ Anterior Crossbite
- ☐ Open Bite
- ☐ TMJ
- ☐ Other - Explain: ______________________________

For Pediatric Dental Treatment

- ☐ Recommended Treatment: ______________________________

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- ☐ X- Rays Taken: ______________________________
- ☐ Comments: ______________________________