Dentist Referral Form

American Association of Orthodontists

DOS Donated Orthodontic Services

Referring Dentist: Your patient has applied to received Donated Orthodontic Services. Please complete the referral form on their behalf.

Mail: AAO, Attn: Donated Orthodontic Services
401 North Lindbergh Blvd., St. Louis, MO 63141
Fax: 314.689.0293
Questions: 1.800.424.2841 x582

Today's Date:

Patient Name: **DOB:**

Date of last appointment: _____

How often is the patient seen in your office? _____

Does the patient's family keep appointments?	☐ Yes	☐ No
Is the patient in need of orthodontic treatment?	☐ Yes	☐ No
Is the child motivated to receive orthodontic treatment?	☐ Yes	☐ No

Description of Patient's Current Condition:				
Malocclusion	☐ Class I	☐ Class II	☐ Class III	
Spacing	☐ Mild ≤ 3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7 mm	
Crowding	☐ Mild ≤ 3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7 mm	
Overjet	☐ Normal	☐ Moderate 2-5mm	☐ Severe ≥ 6mm	
Crossbite	☐ None	☐ Anterior	☐ Posterior	
Overbite	☐ Normal	☐ Moderate (50-75%)	☐ Severe > 75%	☐ Open Bite
Misalignment	☐ None	☐ Mild	☐ Moderate	☐ Severe
Description of Dentition:		☐ Primary	☐ Mixed	☐ Permanent
Is the patient carries free?		☐ Yes ☐ No		
Does the Patient have good oral hygiene?		☐ Yes ☐ No		

Comments:

Dentist Name *(Please Print)*

Dentist Signature

Dentist Phone Number

Thank you for your assistance!