First Impressions S.C.
PEDIATRIC DENTISTRY & ORTHODONTICS

*I am referring_____ *DOB_____ for treatment.

Parent(s) Name_____ *Phone_____

Parent(s) Address _____

_____

Dr. (print name) _____ Phone_____

Dr. (signature) _____ Date_____

*Required

INSURANCE

Please check all that apply:

☐ Primary _____ ☐ BadgerCare

☐ Medical Assistance ☐ Other _____

PEDIATRIC DENTISTRY

The following was completed: ☐ Exam ☐ X-rays (please send) ☐ Prophylaxis

Reason for referral: ☐ Behavioral Management ☐ Caries ☐ Other _____

ORTHODONTICS

Specific concerns:

☐ Class II ☐ Class III

☐ Crossbite(s)_____ ☐ Space Maintenance_____

☐ Tongue/Finger/Thumb habit_____

☐ Impaction _____ ☐ Missing Teeth _____

Additional Concerns_____

_____

Patient/Parent concerned about this? ◯ Yes ◯ No

PATIENT REFERRAL FORM

Which office does the patient prefer? ☐ Wausau ☐ Weston ☐ Rhinelander ☐ Plover

☐ Appleton ☐ Medford ☐ Shawano ☐ Suamico ☐ Bellevue ☐ Marshfield

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