DENTAL REFERRAL FORM

APPLICANT: You must provide both of these pages to your General Dentist and return both pages to AOA upon completion.

☐ Check here to confirm that you have included BOTH pages of the Dental Referral Form in your application packet **and that your dentist has completed the REQUIRED sections.**

Dear Dental Care Provider:
Your patient is applying to Share a Smile, a charitable initiative started by Austin Orthodontic Arts, PLLC with the hopes of receiving braces at no cost. As this child's dental care provider, you play a significant role in the application process by filling out the Dental Referral Form (DRF) below. The DRF helps us determine whether or not a patient is a good candidate for our program. We are screening not only for oral hygiene and orthodontic need but also for applicant motivation. Your participation in this process is critical and makes you an invaluable partner in the Share a Smile program.

Simply fill out the DRF as completely as possible and your patient will include it as a part of their application packet.

· The "General" and "Dental Health" sections are **REQUIRED**; please fill out these sections completely. If these sections are not filled out completely, your patient's application will not be considered.

· The "Functional" section of the DRF is extremely important and helps us gauge the severity of the child's problem. Please provide your professional opinion on this section.

· The family is responsible for taking photos. However, if you have intra/extra oral photos and/or a digital pano x-ray of the child, please give a copy to the family to include with the application.

· Please staple a business card to the DRF so that we can verify that it was filled out by you or a designated staff member.

If you have any additional comments you would like to provide directly and privately to Austin Orthodontic Arts regarding this child, please e-mail us at information@austinorthodonticarts.com, and be sure to include the child's full name and date of birth. Thank you very much for taking the time to fill out this child's DRF, and starting them on the road to a new smile and renewed confidence.

DENTIST INFORMATION:

This section is **REQUIRED.** Application will not be considered if this section is not fully completed.

Patient Name: _____
(First) (MI) (Last)

Dentist Name:_____
(First) (Last)

Dentist Address:_____
(Street) (City) (State) (ZIP Code)

Dentist Phone Number*:_____ e-mail:_____

**Important for verification purposes*

(Continued on next page)

NOTE: Application must be received within 30 days of examination date

DENTAL HEALTH & GENERAL INFO:

CARIES: Does this patient need restorative work at this time? ☐ Yes ☐ No

(**If "yes", child MUST have restorative work completed <u>before</u> submitting this application.** The application will NOT be considered if the child has cavities.)

Does this child have god oral hygiene? ☐ Yes ☐ No (Yes or No response ONLY)		How many deciduous (baby) teeth are present? (If none, write 0)	
Impacted teeth: ☐ Yes ☐ No	Physically capable of cleaning teeth: ☐ Yes ☐ No	Missing Teeth: ☐ Yes ☐ No	Have second molars erupted? ☐ Yes ☐ No

Other Functional or Aesthetic Problems/Comments:

How long has this child been your patient: ☐ < 1 year ☐ 1-3 years ☐ 3+ years	Do you recommend this child for treatment by an orthodontist? ☐ Yes ☐ No
Does this patient/family have a positive attitude toward dental care: ☐ Yes ☐ No	Does this family/patient keep appointments: ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely
Does this child have a moderate to severe need for orthodontic treatment? ☐ Yes ☐ No	Is the child AND parent/guardian motivated and interested in orthodontic care? ☐ Yes ☐ No

FUNCTIONAL: This section is extremely important. Please give your professional opinion.

Malocclusion:	☐ Class I	☐ Class II	☐ Class III	
Upper Crowding:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Lower Crowding:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Upper Spacing:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Lower Spacing:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Overjet:	☐ Normal	☐ Moderate 2-5mm	☐ Severe ≥ 5mm	☐ Underjet
Overbite:	☐ Normal	☐ Moderate (50-75%)	☐ Severe > 75%	☐ Open bite
Crossbite:	☐ None	☐ Anterior	☐ Posterior	
Overall Misalignment:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Date of most recent examination: _____ Application <u>must</u> be received within 30 days of examination date

_____ _____ **(Please attach business card for verification)**

Dentist Signature (**REQUIRED**) Date Signed