BERKELEY ORTHODONTICS
DRS. KASROVI, MEYER, KIM, UNG, AND HOANG

SOUTH BERKELEY
2640 Telegraph Ave., Suite 201
Berkeley, CA 94704
(510) 849-2434

NORTH BERKELEY
910 Ensenada Avenue
Berkeley, CA 94707
(510) 528-1511

ORINDA
96 Davis Road, Suite 1
Orinda, CA 94563
(925) 253-4900

DOCTOR REFERRAL FORM

DOCTOR INFORMATION

REFERRING DOCTOR'S NAME: _____ PRACTICE NAME: _____

DOCTOR'S PHONE: _____ OFFICE ☐ CELL ☐ OTHER ☐ IS IT OKAY TO CALL WITH QUESTIONS? YES ☐ NO ☐

DOCTOR'S EMAIL ADDRESS: _____

PATIENT INFORMATION

PATIENT'S NAME: _____ MALE ☐ FEMALE ☐ D.O.B.: _____

IS IT OKAY TO CALL THE PATIENT TO SCHEDULE AN APPOINTMENT? YES ☐ NO ☐

PATIENT'S PHONE: _____ OFFICE ☐ CELL ☐ OTHER ☐

WHAT ARE YOUR SPECIFIC CONCERNS REGARDING THIS PATIENT? PLEASE CHECK ALL THAT APPLY.

☐ CLASS II
☐ CLASS III
☐ DEEP BITE
☐ OPEN BITE
☐ CROSS BITE
☐ EXCESSIVE OVERJET
☐ CROWDING
☐ TMD
☐ IMPACTED TEETH
☐ MISSING TEETH
☐ OTHER: _____

ANY ADDITIONAL DENTAL PROBLEMS? PLEASE CHECK ALL THAT APPLY.

☐ ORAL SURGERY ☐ PERIODONTAL ☐ ENDODONTIC ☐ IMPLANTS

ARE ANY OF THE FOLLOWING RADIOGRAPHS AVAILABLE TO BE SENT? PLEASE CHECK ALL THAT APPLY.

☐ PERIAPICALS ☐ PANORAMIC ☐ BITE WING ☐ FULL MOUTH

IN TERMS OF ORAL HYGIENE AND/OR PERIODONTAL HEALTH, IS THE PATIENT CLEARED TO PROCEED WITH ORTHODONTIC TREATMENT?

YES ☐ NO ☐

PLEASE PROVIDE ANY ADDITIONAL INFORMATION YOU WANT US TO KNOW.

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