**PEDIATRIC DENTAL CENTER OF Avon**

**Dr. Allison Greenberg, DDS**
Board Certified Orthodontist
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Introducing Patient: ______________________________________________ Birthdate: _______/________/_______

Referring Provider Name: ____________________________________________________ Date: _____/______/______

☐ Please Call Patient, Phone #: ______________ ☐ Patient Will Call For Appointment

**Procedure(s) Requested**

☐ General Orthodontic Evaluation
☐ Early Intervention/Phase 1 Treatment
☐ Invisalign or Invisalign Teen
☐ Skeletal Discrepancy (Cl II/Cl III)
☐ Crowding
☐ Spacing
☐ Other:_______________________________________

☐ Pre-Restorative Ortho
☐ Impactions
☐ Crossbite
☐ Open Bite
☐ Thumb Habit, Tongue Thrust

| RIGHT | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | LEFT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | A | B | C | D | E | F | G | H | I | J | | | | |
| | | | | T | S | R | Q | P | O | N | M | L | K | | | | |
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | |

**Dental History**

Date of Last X-rays: ___/____/____ : ☐ Pano ☐ Other: ______________

☐ Treatment attempted ☐ Treatment not attempted

**Comments:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Please email this referral and any x-rays to mail@pdcofavon.com. Thank you!**