



Camden Pediatric Dentistry

ORTHODONTICS
"WHERE WE CREATE BEAUTIFUL SMILES"



Dr. B. Brian Han • Dr. Varsha Kapoor • Dr. Carly Cotten • Dr. Kent Washington

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Introducing: _____ Age: _____

Date of Birth: _____ Phone: _____

Referred by: _____

Reason for referral: Please check the box that applies.

Pediatric

Orthodontic

- Comprehensive Evaluation
- Emergency or Limited Treatment
- Dental Abscess
- Sedation/General Anesthesia
- Difficult Behavior
- Special Health Needs
- Other _____

- Comprehensive Orthodontic Evaluation
- Early/Interceptive Treatment Evaluation
- Invisalign Consultation
- Growth/Skeletal Evaluation
- Deep-bite/Open-bite
- Anterior/Posterior Crossbite

Radiographs: Emailed Please Take Given to Parent/Patient

Dental Restorations: Have Attempted Have NOT Attempted

Evaluate the Following Teeth/Area: Please Circle.

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	

Special Remarks: _____

Insurance: _____ ID _____

Subscriber: _____ DOB _____

Employer: _____

Please email to: referral@camdenpeds.com

Thank you for your referral!

