madisonorthodonticcenters
Thomas P. Kuhn D.D.S. M.S. Board Certified

6105 Monona Drive, Monona, WI 53716
(608) 663-8819 • Fax (608) 661-8257

HEALTH CHECK EXAM REFERRAL FORM

RECIPIENT NAME: ____

***Date of most recent <u>Health Check Exam</u>**: ________________________________

The Health Check Exam must have been completed within the last 12 months. If not, a new Health Check Exam must be performed.

Referral for Orthodontic Treatment

PHYSICIAN NAME: ____________________________________ PHONE: __________
(not dentist) Please print

PHYSICIAN SIGNATURE: ____________________________________**DATE:**_________
Signature and date required

BRING THIS COMPLETED FORM TO YOUR ORTHODONTIC APPOINTMENT

DO NOT FAX OR MAIL