JAMES R. WATERS, DDS, MSD, PA

Contemporary Orthodontics and Dentofacial Orthopedics

Treatment for Children, Teens & Adults

Patient's First Name: ___________________**Last Name:**__________________ **Age:** _______

Parent's Name: ____

Referring Doctor: ____________________________________ **Date:** ___________________

Reason for Referral:

- ❑ **Open Bite**
- ❑ **Deep Bite**
- ❑ **Excessive Overjet**
- ❑ **Underbite**
- ❑ **Severe Crowding**
- ❑ **Submerged Tooth**
- ❑ **Impacted Tooth/Teeth**
- ❑ **Missing Tooth/Teeth**
- ❑ **Anterior Crossbite**
- ❑ **Posterior Crossbite**
- ❑ **Other: (list below)**

Please attach any digital radiographs by clicking the submit button below. Once you click the submit button you will then be asked to browse/upload/submit any digital radiographs needed. If you have any problems submitting your digital radiographs please send them directly to info@bracesaustin.com