



ORTHODONTIC PATIENT REFERRAL FORM

Patient Information

Name: _____
 Birth date: _____ Gender: M F
 Address: _____

 Phone: _____
 Dental Ins: _____
 Medical Ins: _____
 ID #: _____

Preferred Doctor

First available
 Dr. Bret Gruender

Referred by:

Name: _____
 Facility: _____
 Phone: _____

Radiographs:

Enclosed Patient will bring None provided Will be sent On AxiUm

To transfer patient records and radiographs electronically, please visit the following URL:

<https://sdm.siu.edu/xraydropboxfp/uploadxrays.php>.

Please include your office name/phone number, patient name/date of birth, and date of radiographs.

Reason for consultation: _____

