ORTHODONTICS

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Date: ....

Patient Name: ....

Referred By: ....

PLEASE EVALUATE FOR:

- ☐ Crowding
- ☐ Spacing
- ☐ Protusive Teeth
- ☐ Retrusive Teeth
- ☐ Crossbite
- ☐ Deep Overbite
- ☐ Open Bite
- ☐ Growth problems
- ☐ Preprosthetic Tooth Movement
- ☐ Other

Remarks: ....

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You have been referred to our office for an initial orthodontic examination.
Our office committed to the highest standards in care and personalized service.
The initial examination is completed at no charge to you and there is no
obligation to proceed with treatment.