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Introducing _____ Age _____

Patient's telephone number _____

Parent's name _____ Cell number _____

For:

☐ Full orthodontic evaluation and treatment as indicated.

☐ Evaluation particularly noting the following problem(s):

- ☐ Crowding, spacing.
- ☐ Jaw size/growth discrepancy (Class II, Class III, asymmetry)
- ☐ Open bite, deep bite.
- ☐ Crossbite(s) (anterior, posterior, narrow palate)

Comments _____

_____

_____

_____

Radiographs:

Full mouth series available	☐ Dated _____
Bitewing type available	☐ Dated _____
Panoramic xray available	☐ Dated _____
CBCT available	☐ Dated _____

Referred by _____ Date _____

Thank you for this referral! We will send an examination summary to you as soon as possible after seeing your patient.

PLEASE FOLD, TAPE AND MAIL THIS COPY TO DR. MARCEL (ADDRESS ON REVERSE)