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For Dental /Medical Professional Use Only

Introducing: _____ Birthdate: _____

Referring Dr: _____

An appointment has been made on (date & time): _____

Please evaluate the following:

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Openbite | <input type="checkbox"/> Class II |
| <input type="checkbox"/> Crossbite | <input type="checkbox"/> Excessive Overjet | <input type="checkbox"/> Class III |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Impaction(s) | |

Remarks:

Please print, complete, and email to info@ossfw.com or fax to 260-489-4853 (Fort Wayne office)
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Orthodontics
Aron Dellinger, D.D.S., M.S.D.

