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Referring Doctor: _____

This will introduce: _____

For the Orthodontic Evaluation of:

- | | | |
|--|---|--|
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Spacing | <input type="checkbox"/> Crossbite |
| <input type="checkbox"/> Overjet | <input type="checkbox"/> Deep Bite | <input type="checkbox"/> Underbite |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Early or Late Loss of Teeth |
| <input type="checkbox"/> Facial Growth | <input type="checkbox"/> Oral Habit | <input type="checkbox"/> Pre-Prosthetic Needs |

Comments: _____
