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ORTHODONTICS GROUP

DAVID SHEN, DMD & ASSOCIATES
SPECIALISTS IN ORTHODONTICS AND CLEAR ALIGNERS

Referral Form

Patient's Full Name _____ **Date** _____

For the orthodontic evaluation of:

☐ Crowding	☐ Spacing	☐ Cross Bite
☐ Overjet	☐ Deep Bite	☐ Under Bite
☐ Missing Teeth	☐ Impacted Teeth	☐ Open Bite
☐ Premature Loss of Primary Teeth	☐ Oral Habit	☐ Pre-Prosthetic Needs
☐ Delayed Exfoliation	☐ Facial Growth	☐ Other, please describe below.

Referring Doctor _____

Comments

_____

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Call or email to make an appointment today for a free consultation!

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