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**Date:** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Referred by Doctor:** \_\_\_\_\_

**Current Panoramic/FMX are available:** Yes\_\_\_ No\_\_\_

**Area of Concern:**

- Crossbite     Crowding     Spacing     Missing Tooth  
 Overjet     Overbite     Impacted Tooth

**Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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