



BYTOWN ORTHODONTICS

Dr. David Chambers
Dr. Carine Bourassa
ORTHODONTISTS

Patient Name _____ Date _____

Patient Phone _____ Date of Birth _____

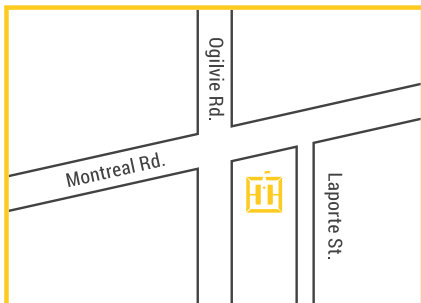
Referred by _____

Areas of Concern:

- | | | |
|---|--|--|
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Spacing | <input type="checkbox"/> Openbite |
| <input type="checkbox"/> Overjet | <input type="checkbox"/> Overbite | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Pre-prosthetics | <input type="checkbox"/> Space Maintenance |
| <input type="checkbox"/> Crossbite | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Early or Interceptive Treatment |
| <input type="checkbox"/> Other _____ | _____ | |

Dental History:


- | | |
|--|--|
| <input type="checkbox"/> Date of last cleaning & checkup _____ | |
| <input type="checkbox"/> Panoramic radiograph is available | <input type="checkbox"/> Restorative work needed |




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