BYTOWN ORTHODONTICS

Dr. David Chambers
Dr. Carine Bourassa
ORTHODONTISTS

Patient Name _____ DOB _____

Patient Phone _____ Email Address _____

Referred By _____ Date _____

Preferred Language ☐ English ☐ French

Areas of Concern:

☐ Crowding ☐ Spacing ☐ Openbite

☐ Overjet ☐ Overbite ☐ Orthognathic Surgery

☐ Impacted Teeth ☐ Pre-prosthetics ☐ Space Maintenance

☐ Crossbite ☐ Missing Teeth ☐ Early or Interceptive Treatment

☐ Other _____

_____

Dental History:

☐ Panoramic radiograph is available Date _____

☐ Examination/cleaning Date _____

☐ Periodontal charting is available Date _____

☐ Restorative work needed

2084 Montreal Rd, Ottawa ON K1J 6M9 smile@bytownortho.com

www.bytownortho.com 613-518-1145 613-800-0501