



LEE

ORTHODONTICS

David Lee, DDS, MSD

BOARD CERTIFIED ORTHODONTIST

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PRACTICE LIMITED TO ORTHODONTICS

Patient: _____ Date: _____

Referring doctor: _____ Tel: _____

Appointment date and time: _____

Reason for referral:

Crowding / Spacing

Deepbite / Openbite

Crossbite

Excess overjet

Impacted teeth

Missing teeth

Space maintenance

Habit correction

Other _____

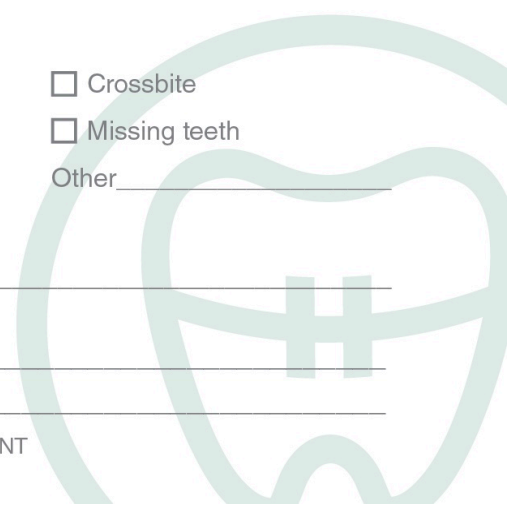
Restorative treatment:

is completed

is underway _____

Comments:

PLEASE BRING THIS FORM TO YOUR APPOINTMENT



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