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 theatment:

- ☐ is completed
- ☐ is underway_____

Comments:

_____

_____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

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