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DR. CURTIS CONTRO

Orthodontist

PATIENT INFORMATION

Patient Name:

Patient's Number:

Referring Doctor:

Patient's Email:

AREA OF CONCERN

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Class II | <input type="checkbox"/> Class III | <input type="checkbox"/> Crowding |
| <input type="checkbox"/> Spacing | <input type="checkbox"/> Deep Bite | <input type="checkbox"/> Open Bite |
| <input type="checkbox"/> Cross Bite | <input type="checkbox"/> Finger Habit | <input type="checkbox"/> Tongue Thrust |
| <input type="checkbox"/> Need Space for Restoration | <input type="checkbox"/> Other: | |

Click or tap here to enter text.

TYPE OF TREATMENT PATIENT SEEKING

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Just a Check – Up | <input type="checkbox"/> Early Interceptive Treatment | <input type="checkbox"/> Invisalign |
| <input type="checkbox"/> Braces | <input type="checkbox"/> Pre – Restorative Treatment | <input type="checkbox"/> Retainers |
| <input type="checkbox"/> Other: | | |

ADDITIONAL INFORMATION

