



# David Shen, DMD & Associates

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Date: \_\_\_\_\_

This will introduce: \_\_\_\_\_

## For the Orthodontic Evaluation of:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Crowding                        | <input type="checkbox"/> Spacing        | <input type="checkbox"/> Cross bite                  |
| <input type="checkbox"/> Overjet                         | <input type="checkbox"/> Deep bite      | <input type="checkbox"/> Under bite                  |
| <input type="checkbox"/> Missing teeth                   | <input type="checkbox"/> Impacted teeth | <input type="checkbox"/> Open bite                   |
| <input type="checkbox"/> Premature loss of primary teeth | <input type="checkbox"/> Oral habit     | <input type="checkbox"/> Pre-prosthetic needs        |
| <input type="checkbox"/> Delayed exfoliation             | <input type="checkbox"/> Facial growth  | <input type="checkbox"/> Other please describe below |

Referring Doctor: \_\_\_\_\_

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