

Hi 5 ORTHODONTICS

PATIENT INFORMATION

Date _____

Name _____

Phone _____ D.O.B. _____

Email _____

DOCTOR INFORMATION

Referring Dr. _____

Office Phone _____

Date of Last Exam/Cleaning _____

CONCERNS

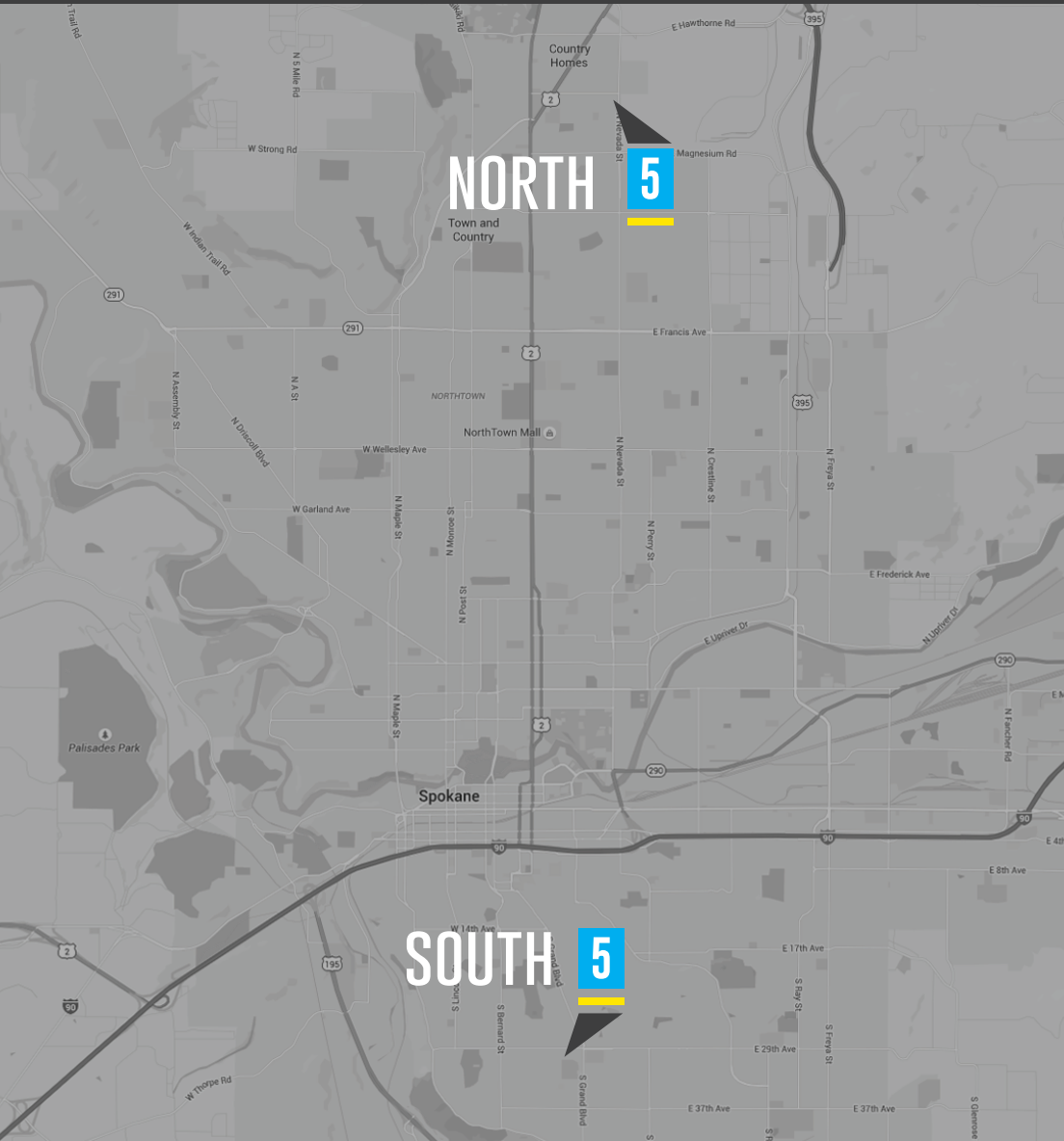
Check all that apply

- | | | |
|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Crossbite | <input type="checkbox"/> Invisalign | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> TMD |
| <input type="checkbox"/> Deep Bite | <input type="checkbox"/> Openbite | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Habits | <input type="checkbox"/> Overjet | _____ |
| <input type="checkbox"/> Impactions | <input type="checkbox"/> Skeletal Discrepancy | _____ |

Dr. Comments _____

Pt. Concerns _____

Hi5 ORTHODONTICS



NORTH 5

SOUTH 5

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Spokane, WA 99218

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Hi5 SMILES BY DR. AARON WILLIAMS