Hi5 ORTHODONTICS

PATIENT INFORMATION

Date _____

Name _____

Phone _____ D.O.B. _____

Email _____

DOCTOR INFORMATION

Referring Dr. _____

Office Phone _____

Date of Last Exam/Cleaning _____

CONCERNS

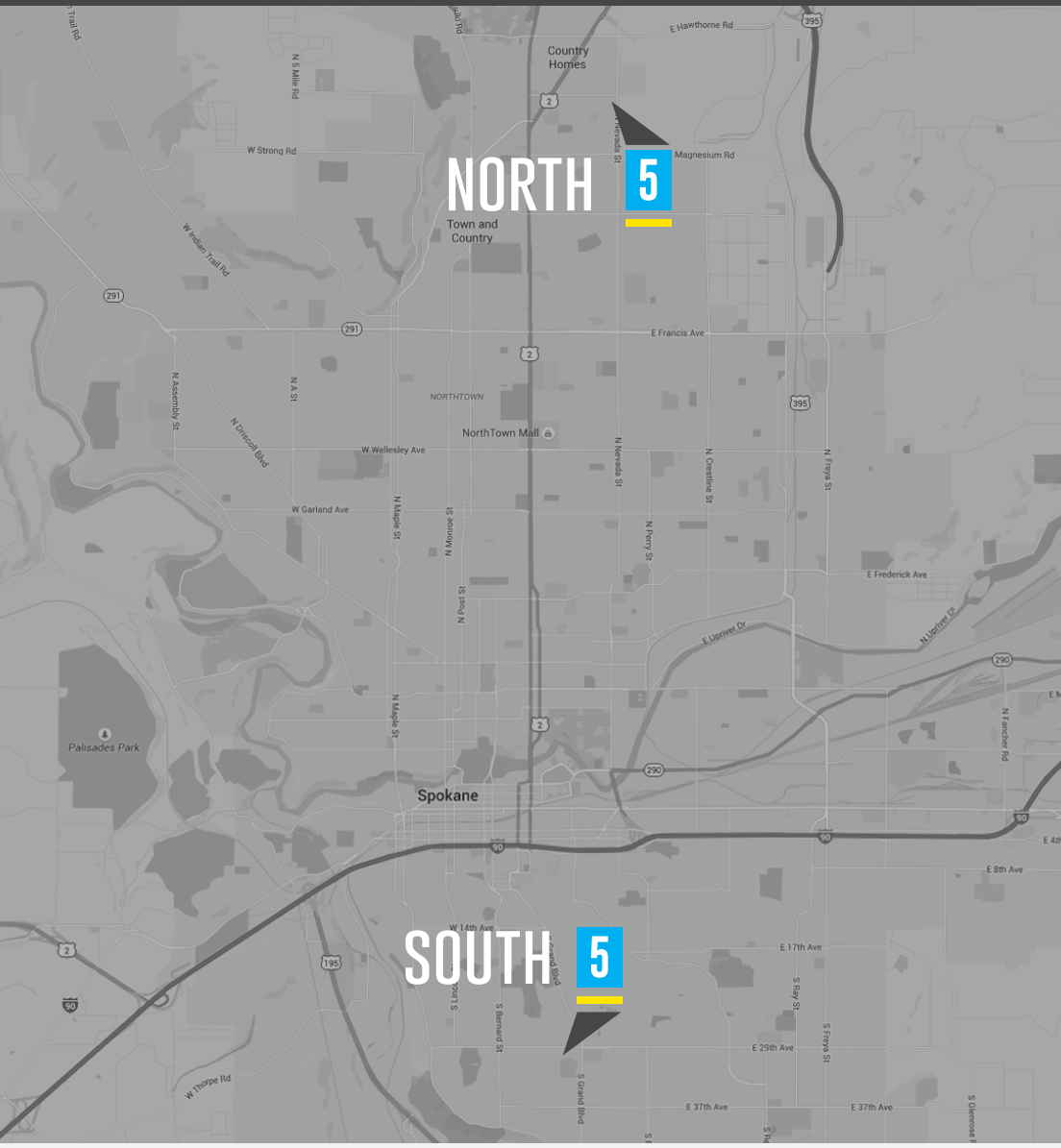
Check all that apply

- ☐ Crossbite
- ☐ Crowding
- ☐ Deep Bite
- ☐ Habits
- ☐ Impactions
- ☐ Invisalign
- ☐ Missing Teeth
- ☐ Openbite
- ☐ Overjet
- ☐ Skeletal Discrepancy
- ☐ Sleep Apnea
- ☐ TMD
- ☐ Other _____

Dr. Comments _____

Pt. Concerns _____

Hi5 ORTHODONTICS



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