Orthodontics
Smiling Smiles Pty Ltd

Date: _____

Dentist Name: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

DIAGNOSIS

- ☐ Irregularity
- ☐ Crowding
- ☐ Spacing
- ☐ Protrusion
- ☐ Cross bite/reverse OB
- ☐ Deep bite
- ☐ Other: ……

- ☐ Class II
- ☐ Class III
- ☐ TMJ
- ☐ Perio
- ☐ Pre-restorative concerns
- ☐ Missing/extra teeth

Comments: _____

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Chatswood NSW 2067

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