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CORSA ORTHODONTICS

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Date_____

Introducing_____ DOB_____

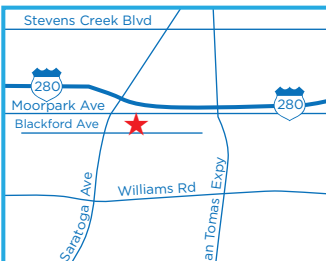
From_____

Patient's Phone Number_____

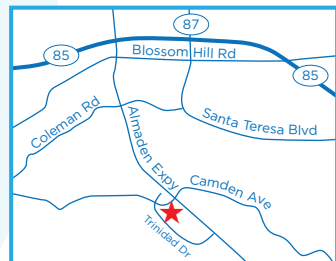
PLEASE EVALUATE FOR:

- | | |
|---|--|
| ☐ Crowding / Spacing | ☐ Missing Teeth |
| ☐ Rotation | ☐ Protrusive Teeth |
| ☐ Deep Bite / Open Bite | ☐ Facial Growth Problems |
| ☐ Crossbite | ☐ Multidisciplinary Treatment |
| ☐ Excess Overjet | ☐ Full orthodontics |
| ☐ Occlusal Discrepancies | ☐ Invisalign |
| ☐ Oral Habits | ☐ Early or interceptive treatment |

Additional Comments _____



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Member
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Association of
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