perforation line

northern colorado
orthodontics

Patient Name: _____

Phone: _____ DOB: _____

Referring Dr: _____ Date: _____

Patient sent with radiographs: Y N

Please examine for the following:

- ❑ Crowding
- ❑ Spacing
- ❑ Overjet
- ❑ Underbite
- ❑ Overbite
- ❑ Openbite
- ❑ Crossbite
- ❑ Impacted teeth
- ❑ Missing teeth
- ❑ Retained teeth
- ❑ Habit
- ❑ Other

Notes: _____

_____

_____

_____

_____

Jill K. Mioduski, DDS, MS, Prof. LLC

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