



# Pure Smiles

ORTHODONTICS

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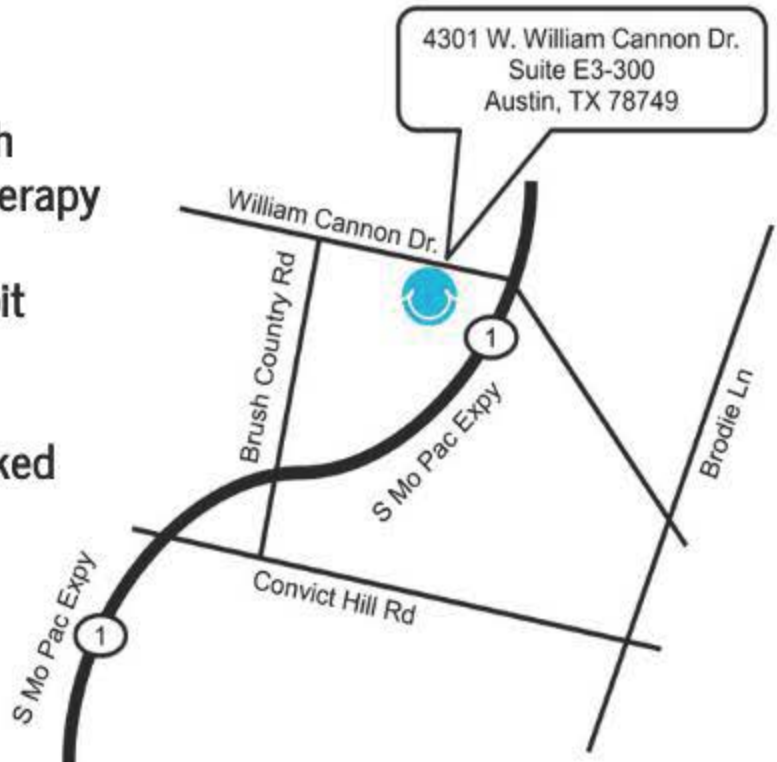
Referred by Dr. \_\_\_\_\_

Office Phone No. \_\_\_\_\_

Patient Name \_\_\_\_\_

Remarks \_\_\_\_\_

- Please evaluate for full orthodontic treatment
- Please evaluate for arch expansion/crossbite therapy
- Please evaluate for habit reminder therapy
- Please evaluate for blocked out/impacted teeth



Signature \_\_\_\_\_

Date \_\_\_\_\_