



# MC ORTHODONTICS

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 INTRODUCING: \_\_\_\_\_

 TELEPHONE #: \_\_\_\_\_

 REFERRAL DATE: \_\_\_\_\_

 REFERRAL BY: \_\_\_\_\_

### REASONS FOR REFERRAL:

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> CROWDED TEETH    | <input type="checkbox"/> OPEN BITE  |
| <input type="checkbox"/> MISSING TEETH    | <input type="checkbox"/> DEEP BITE  |
| <input type="checkbox"/> PROTRUSIVE TEETH | <input type="checkbox"/> CROSS BITE |
| <input type="checkbox"/> RETRUSIVE TEETH  | <input type="checkbox"/> TMJ        |
| <input type="checkbox"/> OTHER            |                                     |

REMARKS: \_\_\_\_\_

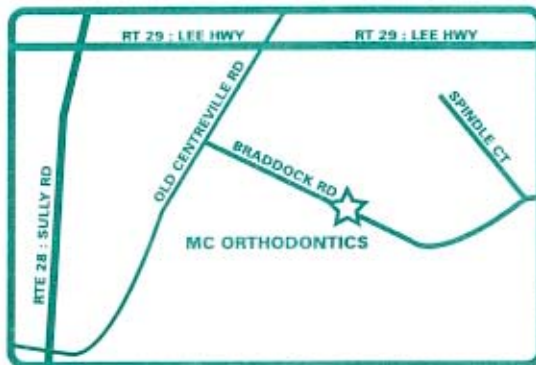
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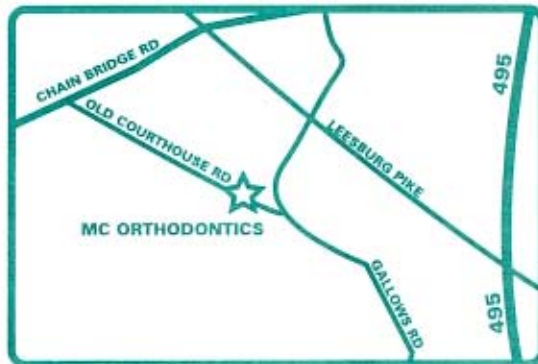
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