James R. Waters, DDS, MSD

Diplomate American Board of Orthodontics
Treatment For Children, Teens And Adults

Patient's Name: _____ **Age:** _____

Parent's Name: _____

Referring Doctor: _____ **Date:** _____

Reason for Referral:

- ❑ **Open Bite**
- ❑ **Deep Bite**
- ❑ **Excessive Overjet**
- ❑ **Underbite**
- ❑ **Severe Crowding**
- ❑ **Other:** _____
- ❑ **Submerged Tooth**
- ❑ **Impacted Tooth/Teeth**
- ❑ **Missing Tooth/Teeth**
- ❑ **Anterior Crossbite**
- ❑ **Posterior Crossbite**

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