

introducing



introducing: _____

date: _____ age: _____

phone: h _____ w _____

referred by: _____

please evaluate:)))

- | | | |
|------------------------------------|---|--|
| arch length | dental concerns | occlusion |
| <input type="checkbox"/> crowding | <input type="checkbox"/> missing or extra teeth | <input type="checkbox"/> deep bite |
| <input type="checkbox"/> spacing | <input type="checkbox"/> delayed eruption | <input type="checkbox"/> open bite |
| crossbite | <input type="checkbox"/> small or large teeth | <input type="checkbox"/> overjet |
| <input type="checkbox"/> anterior | <input type="checkbox"/> impaction | <input type="checkbox"/> excessive wear |
| <input type="checkbox"/> posterior | | <input type="checkbox"/> traumatic occlusion |

xrays: included will mail|e mail please take

please call me to discuss the care of my patient.

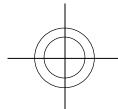
comments:)))

brad a. chvatal, dmd, ms

2650 suzanne way, suite 170
eugene, oregon 97408
541 683 8490

1130 east main street
cottage grove, oregon 97424
541 942 0401

www.eugenebraces.com



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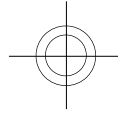
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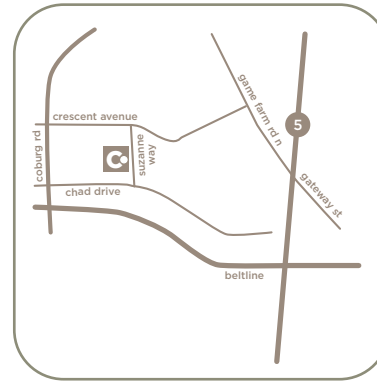
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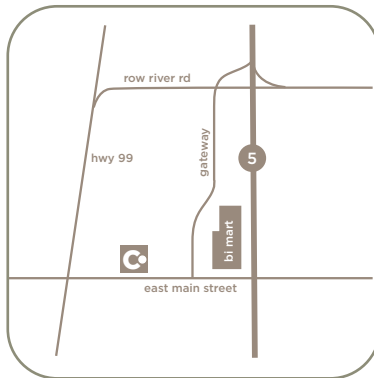


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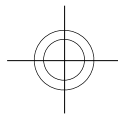
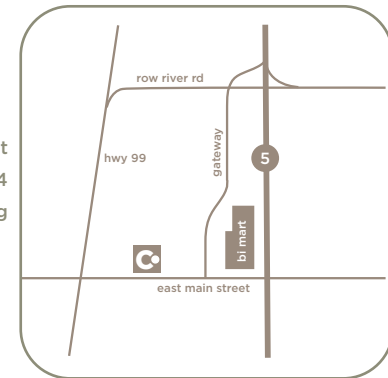


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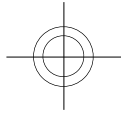
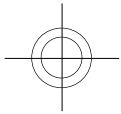
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