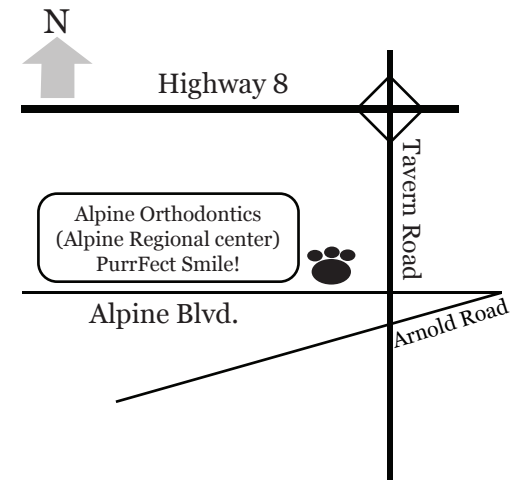


ALPINE ORTHODONTICS

Cynthia L. Jackson, D.D.S., M.S.
Orthodontist



Introducing _____ Age _____

Patient's telephone number _____ (H) _____ (W) _____

Patient's will call for appointment

Please call patient to schedule appointment

Appointment Date And Time _____

FOR : Full Orthodontic Evaluation And Treatment As Indicated Evaluation Particularly Noting The Following Problems:

<input type="checkbox"/> Patient's Parent's Chief Complaint	<input type="checkbox"/> Crowding Spacing, Missing Or Extra Teeth	<input type="checkbox"/> Jaw Size Growth Discrepancy (Class Ii, Class Iii, Asymmetry)	<input type="checkbox"/> Open Bite, Deep Dite	<input type="checkbox"/> Crossbite(S) (Anterior, Posterior, Narrow Palate)	<input type="checkbox"/> Pre-prosthetic Considerations (Abutment, Preparation, Rotations, Tipping)	<input type="checkbox"/> Other
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Comments _____

Please call me on this patient

RADIOGRAPHS:

Full mouth series available Will be sent

Panographic type available Patient will carry

_____ available Will forward upon request

None available -recommend as needed

Referred by _____ Date _____

Thank you for this referral. We will send an examination summary to you as soon as possible after seeing your patient.