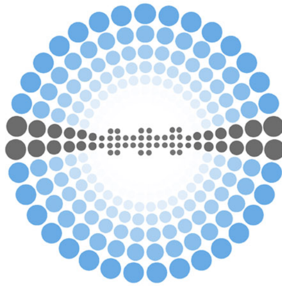

Orthodontic Associates of Iowa

Kaci C. Vela, DDS, MS

DATE: ______________________________

PATIENT NAME: ______________________________

RESPONSIBLE PARTY NAME: ______________________________

PATIENT PHONE: ______________________________

REFERRING DENTIST: ______________________________

PANO DATE: ______________________________

CONCERNS:

- [ ] Crowding
- [ ] Spacing
- [ ] Protrusion
- [ ] Molar Relationship
- [ ] Overjet
- [ ] Crossbite
- [ ] Deep bite
- [ ] Open bite
- [ ] Habit
- [ ] Missing Teeth
- [ ] Pre-prosthetic
- [ ] TMJ Dysfunction

COMMENTS: ______________________________

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