BAKER ORTHODONTICS

david m. baker, dmd

"for people who love to smile"

Date _____

We would like to introduce:

_____

Age _____ for the following concerns:

☐ Excess overset ☐ Underbite ☐ Crowding/Spacing

☐ Chin deficiency ☐ TMD ☐ Sleep disordered breathing/airway

_____

_____

Relevant Health History:

_____

_____

_____

Radiographs

☐ Enclosed ☐ Are being mailed (smile@davidbakerortho.com)

☐ Please take if needed

Referring Doctor _____

Phone _____

Appointment _____ _____ _____

Day Date Time

www.davidbakerortho.com

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