# Orillia Orthodontics

Dr. David Stirling | Dr. Scott MacGregor

**Date** *

Month Day Year

**Patient Name** *

First Name Last Name

**Parent/Guardian Name**

First Name Last Name

**Address** *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

**Phone Number (primary)** *

Area Code Phone Number

**Phone Number (secondary)**

Area Code Phone Number

**Email**

example@example.com

**Referring Doctor** *

Prefix First Name Last Name

**Doctor's Email** *

example@example.com

**Concerns** *

| | | | |
|---|---|---|---|
| ☐ Class I | ☐ Class II | ☐ Class III | ☐ |
| ☐ Crowding | ☐ | ☐ Spacing | ☐ |
| ☐ Excessive Overjet | ☐ | ☐ Excessive Overbite | ☐ |
| ☐ Missing Teeth | ☐ | ☐ Extra Teeth | ☐ |
| ☐ Impactions | ☐ | ☐ Ectopic Eruption | ☐ |
| ☐ Crossbite | ☐ Anterior | ☐ Open Bite | ☐ Anterior |
| ☐ | ☐ Posterior | ☐ | ☐ Posterior |

**Habits**

☐ Thumb ☐ Finger ☐ Throat Thrush

**Prosthetic**

☐ Extrusion ☐ Uprighting ☐ Other

**Orthodontic**

☐ Surgery ☐ Clear Braces ☐ Invisalign

**RADIOGRAPHS AVAILABLE**

Panorex

**Date**

Month Day Year

**Type a question**

◯ Booked ◯ Call Patient ◯ Patient to call

**Comments**