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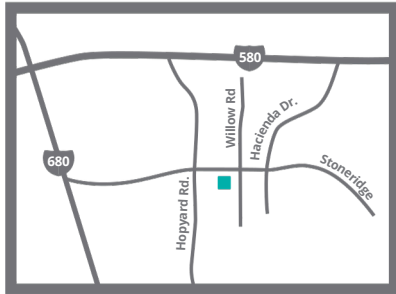
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**Scan to Schedule Your
Complimentary Consultation**

Today's Date: _____ Referred by _____

Patient's Name _____ DOB _____ Gender _____

Parents' Name _____

Address _____

Phone _____ Email _____

Comments _____

Primary Concerns

- Crowding Open Bite Deep Bite Cross Bite
- Class II Class III Abnormal Habit Other

Panorex/Full Mouth

- None Emailed Mailed Released to patient

Restorative Treatment

- Complete Incomplete Projected Completion Date _____

Please email a copy: bairdorthodontics@emaildds.com