AbrahamOrthodontics

Dr. Maxwell Abraham DDS MS FRCD(C)

Certified Specialist in Orthodontics & Dentofacial Orthopedics

Request for a Complimentary Orthodontic Evaluation

Date: _____ Referring Office: _____

Dentist or Hygienist:_____ Staff Member:_____

Patient's Full Name: _____

Address: _____

Number Street Apt. City Province Postal Code

Gender:_____ DOB:_____

Patient's Guardian Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

E-Mail:_____ Preferred Appointment Day/Time:_____

Area of Concern: (Optional)

- ☐ **Crowding**
- ☐ **Spacing**
- ☐ **Premature Loss of Tooth**
- ☐ **Pre- Restorative**
- ☐ **Missing Teeth**
- ☐ **Impacted Teeth**
- ☐ **Overjet**
- ☐ **Facial Growth**
- ☐ **Oral Habit**
- ☐ **Other (Specify Below)**
- ☐ **Cross Bite**
- ☐ **Under Bite**
- ☐ **Deep Bite**
- ☐ **Open Bite**

Clinical Notes:

Is the patient undergoing active dental treatment? ☐ **Yes** ☐ **No** **Specify:** _____

Periodontal Records current (Adults)? ☐ **Yes** ☐ **No** **(Please Update and send)**

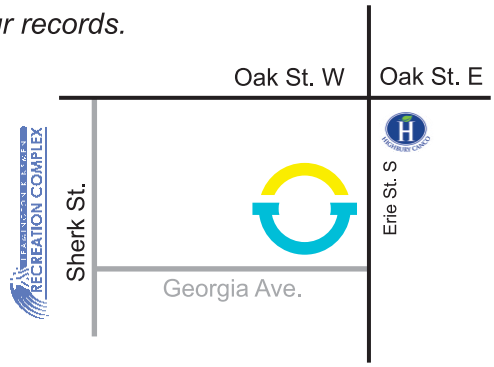
Panoramic X-Ray: ☐ **With Patient** ☐ **Emailed to: Info@AbrahamOrthodontics.com**

Form: ☐ **E-mail** ☐ **Fax** ☐ **Filled Online: AbrahamOrthodontics.com**

Thank you for your trust in our office! Please retain a copy for your records.

Appointment Date:_____

185 Erie St S, Unit 1
Leamington ON, N8H3B9
P: **519-398-8101**
E: Info@**Abraham**Orthodontics.com
www.**Abraham**Orthodontics.com



We are located at the intersection of
Erie St. S & Georgia Ave. in Leamington!