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| Date of Referral: Click here to enter a date. | Patient Name: Click here to enter text. |

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| Referred By: Click here to enter text. |

Evaluate for:

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| [ ]  ALF Appliance | [ ]  Digital Impressions |
| [ ]  TMJ | [ ]  Implants |
| [ ]  CBCT Scan | [ ]  Extraction Site Recovery |
| [ ]  Frenectomy | [ ]  Orthodontic Aligners |
| [ ]  Sleep Apnea | [ ]  Safe Amalgam Removal |

Notes: Click here to enter text.

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| --- | --- | --- | --- |
| Xrays/Scans: | [ ]  Enclosed | [ ]  Sent Separately | [ ]  None |