OLSON ORTHODONTICS

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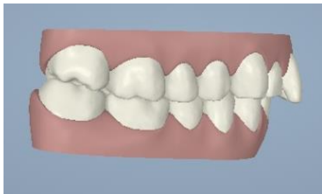
PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR INITIAL NEW PATIENT CONSULTATION

Patient Name: ____ Date: ____________________

Date of birth: ________________________

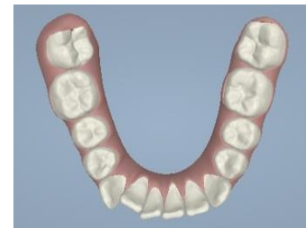
1. What is your main orthodontic concern? Please circle all that apply:

Overjet (buck teeth)



Spaced teeth

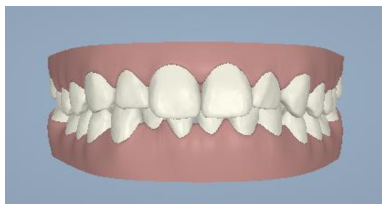
Crowded/Crooked Teeth



Deep Overbite

Open Bite

Other

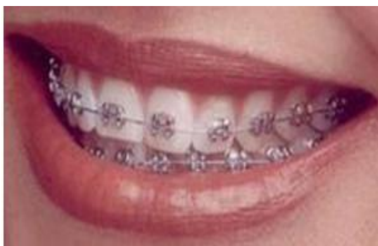


(Please

Explain):

____

2. What type of treatment are you interested in learning more about?



Metal Braces

Clear or Ceramic Braces

Invisalign or Invisalign Teen