PETER LEE
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Specializing in Orthodontics and Dentofacial Orthopedics

ORTHODONTICS PEDIATRIC DENTISTRY

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Please provide an orthodontic evaluation for:

Name: _____ **Age:** _____

- ○ **Crowding / Spacing**
- ○ **Protrusion (Class II)**
- ○ **Eruption Problem**
- ○ **Orthognathic Surgery**
- ○ **Crossbite**
- ○ **Reverse Bite (Class III)**
- ○ **Interdisciplinary Care**
- ○ **Other**

○ **Radiographs Available** **Type:** _____ **Date:** _____

Comments: _____

_____

_____

Referred By: _____ **Date:** _____