Vicki I. Wang, D.D.S

Orthodontics for Children and Adults

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Date:_____

Patient's Name:_____

Patient's Phone:_____

Referred by:_____

Referral's Phone:_____

☐ **Restorative treatment is completed** ☐ **Call me after exam** ☐ **Send written report after exam** ☐ **Recent full mouth/panoramic radiographs are available**

Concerns:_____

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White – Patient Copy Yellow-Doctor's Copy Manila-Mail to Dr. Wang