



Dr. Francis Badejoko

D.D.S, Cert. Ortho

Referred By _____ Date _____

Patient's Name _____

Birth Date _____ Phone _____

Parent / Guardian _____

I Recommend Examining This Patient For The Following

- | | | |
|---------------------------------|--------------------------------------|--------------------------------------|
| <input type="radio"/> Class II | <input type="radio"/> Deep Bite | <input type="radio"/> Overjet |
| <input type="radio"/> Class III | <input type="radio"/> Impacted Teeth | <input type="radio"/> Pre Prosthetic |
| <input type="radio"/> Crossbite | <input type="radio"/> Missing Teeth | <input type="radio"/> Spacing |
| <input type="radio"/> Crowding | <input type="radio"/> Open Bite | <input type="radio"/> TMD |

Remarks _____

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