

LANGLEY ORTHODONTICS

CREATING BEAUTIFUL SMILES

JESKE CORPORATE CENTRE

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Certified Specialists in Orthodontics

www.langleyorthodontics.com

INTRODUCING

Patient Name _____

Birthdate _____ Phone _____

FOR A COMPLIMENTARY ORTHODONTIC EVALUATION

Referred By: _____

Office Name: _____

Office Phone Number: _____

X-Rays Have Been Emailed: office@langleyorthodontics.com

DENTAL INSURANCE INFORMATION

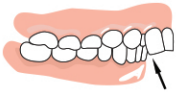
Name of Insurance company: _____

Policy holder name: _____

Policy holder DOB: _____

Group Policy #: _____ Certificate/ID#: _____

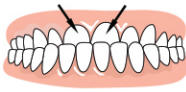
CHIEF CONCERNS



Protrusive Teeth



Deep Over Bite



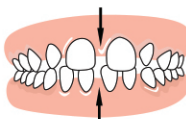
Underbite/
Anterior Crossbite



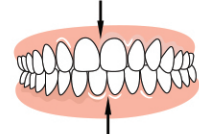
Open Bite



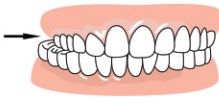
Crowded Teeth



Spaced Teeth



Midline Discrepancy



Posterior Crossbite

invisalign®

Breathing & Airway

TMJ

Please fax or email a copy to our office and give a copy to the patient

