



UP NORTH ORTHODONTICS

Spencer Crouch, DDS, MS

Referring Doctor: _____ Date: _____

Introducing: _____

Parent(s) Name(s): _____

Phone: _____

- | | |
|--|---|
| <input type="checkbox"/> General Orthodontic Eval. | <input type="checkbox"/> Crossbite |
| <input type="checkbox"/> Dental Crowding | <input type="checkbox"/> Ectopic Eruption |
| <input type="checkbox"/> Dental Spacing | <input type="checkbox"/> Impacted Tooth / Teeth |
| <input type="checkbox"/> Open Bite | <input type="checkbox"/> Missing Tooth / Teeth |
| <input type="checkbox"/> Deep Bite | <input type="checkbox"/> Pre-Restorative Concerns |
| <input type="checkbox"/> Excess Overjet | <input type="checkbox"/> Orthognathic Surgery Eval. |
| <input type="checkbox"/> Other: _____ | |

Patient has a recent panoramic x-ray from: _____

Please call or email Office@UpNorthOrthodontics.com
to schedule your COMPLIMENTARY orthodontic evaluation

We look forward to your visit!



Traverse City Office

432 Munson Place

Beulah Office

67 S Benzie Blvd

UpNorthOrthodontics.com | P: 231.946.0070 | F: 231.947.5160