LOWE
ORTHODONTICS
Spectacular Smiles, Exceptional Experience

Zachton J Lowe DDS MSD

Referring Dentist _____ Referral Date _____

Patient Name _____ DOB _____

Parent/Guardian Name (if applicable) _____

Phone Number _____ ☐ Please do not call, patient will contact when ready

Areas of Concern:

☐ Crowding	☐ Spacing	☐ Overjet
☐ Overbite	☐ Openbite	☐ Crossbite
☐ Impacted Teeth	☐ Missing Teeth	☐ Pre-Restorative
☐ Early/Interceptive Treatment		☐ Space Maintenance
☐ Surgical Orthodontics		☐ Retainers

☐ Other _____

_____

_____

Dental History:

☐ Date of last cleaning and checkup_____

☐ Panoramic radiograph is available

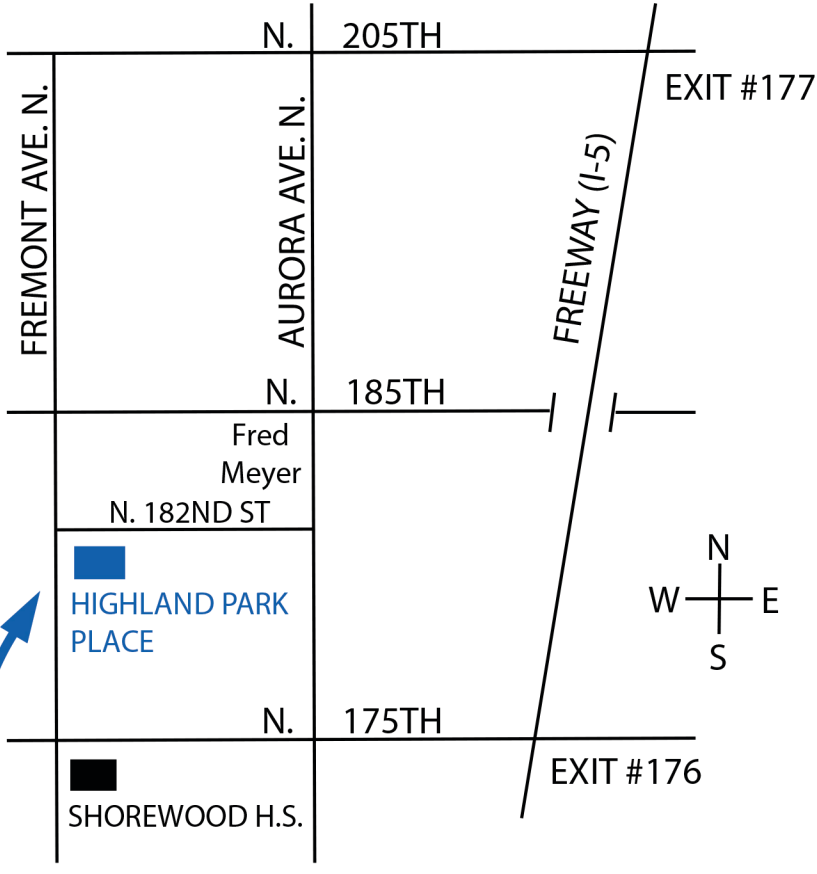
☐ Periodontal chart is available

☐ Restorative work is needed

721 N 182nd St Suite 303
Shoreline, WA 98133

Phone: 206-542-7575
Fax: 206-542-5552
info@loweortho.com

(Please refer to map on reverse side)



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Please visit LOWEORTHO.COM for more information