



# 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: _____                                     |   |
| _____   |   |
| <input type="checkbox"/> Patient has a recent panoramic x-ray from: _____ |   |

Please call or email [Office@UpNorthOrthodontics.com](mailto:Office@UpNorthOrthodontics.com)  
to schedule your COMPLIMENTARY orthodontic evaluation

We look forward to your visit!



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*Beulah Office*

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