UP NORTH ORTHODONTICS

Spencer Crouch, DDS, MS

Referring Doctor: _____ Date: _____

Introducing: _____

Parent(s) Name(s): _____

Phone: _____

- ☐ General Orthodontic Eval.
- ☐ Dental Crowding
- ☐ Dental Spacing
- ☐ Open Bite
- ☐ Deep Bite
- ☐ Excess Overjet
- ☐ Crossbite
- ☐ Ectopic Eruption
- ☐ Impacted Tooth / Teeth
- ☐ Missing Tooth / Teeth
- ☐ Pre-Restorative Concerns
- ☐ Orthognathic Surgery Eval.
- ☐ 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!

invisalign® PROVIDER

michigan dental ASSOCIATION PROUD MEMBER

Member American Association of Orthodontists

Traverse City Office
432 Munson Place

Beulah Office
67 S Benzie Blvd

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