



PITTMAN

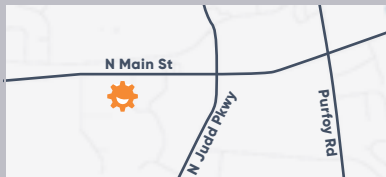
FAMILY ORTHODONTICS

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DATE:

PATIENT'S NAME:

DOB: / / PHONE:

CHIEF CONCERNS:

REFERRING DOCTOR'S NAME: