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PATIENT PROFILE:			
	vith the appearance of your smile?		
	thodontic treatment is needed?		
		the state of the s	
The state of the s	prior orthodontic treatment or appliances?		
Is there any informat	tion that would help us better treat you? _		
MEDICAL HISTORY:			
Now or in the past, h	nas the patient had:		
Secretary to some and the secretary	DN'T KNOW		
	☐ Allergy to latex?		

		List	
		ssure issues?	
	□ Eating Disorder?		
0 0	☐ Environmental allergies, hay	/ tever, asthma?	
MEDICATIONS: List	all medications:		
N N N			<u> </u>
DENTAL HISTORY:			
	accidents or trauma to the teeth or face?		
Are there any missin	g teeth?	A THE RESERVE OF THE PERSON OF	* * * * * * * * * * * * * * * * * * * *
Are there any other d	dental conditions or problems that we sho	uld be aware of?	
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Signed:		Data:	
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MEDICAL HISTORY	UPDATE OR CHANGES:		
Comments:			
Signed:		Date:	
- E.	FOR	OFFICE USE ONLY	DATE:
TMJ	Gingiva Habits		NOTES
Hygiene	Fractures Heredity		
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