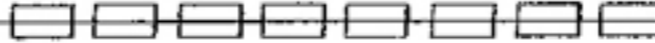


ALL KIDS ORTHODONTICS
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Orthodontic Specialist
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I have Advised My Patient: _____

To Contact your office for a no charge consultation regarding the following:

- | | |
|---|--|
| <input type="checkbox"/> Overjet / Overbite / Openbite | <input type="checkbox"/> Snoring / Sleep Apnea |
| <input type="checkbox"/> Crowding / Spacing / Crossbite | <input type="checkbox"/> Grinding / Clenching |
| <input type="checkbox"/> Pre Implant Alignment | <input type="checkbox"/> TMJ Disorder |
| | <input type="checkbox"/> Other |

Comments: _____

Referring Doctor: _____ Date: _____

Michael Luther, D.D.S, M.P.H.

