



CITY GRIN

ORTHODONTICS

Dr. Eugenia Lee, DMD

Introducing: _____ Birth Date: _____

Referred by Doctor: _____ Date: _____

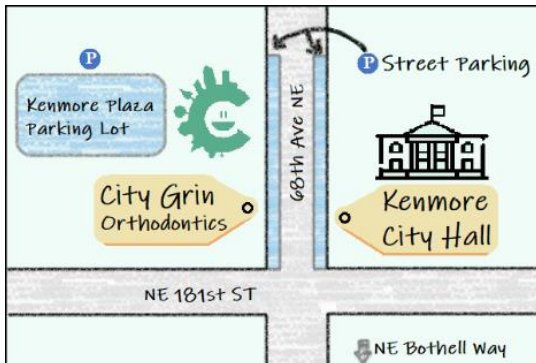
Patient email: _____ Phone: _____

Requested Consultation:

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Class II | <input type="checkbox"/> Deep Bite | <input type="checkbox"/> Spacing |
| <input type="checkbox"/> Class III | <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Interested in |
| <input type="checkbox"/> Crossbite | <input type="checkbox"/> Missing Teeth | Invisalign |
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Open Bite | |

Remarks: _____

Please fax or email most recent pano x-ray to our office. Thank you!



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www.citygrin.com

Contact us for a complimentary consultation! 😊