



1120 East Dupont Rd  
Fort Wayne, IN 46825  
260.497.0497

841 South Union Street  
Warsaw, IN 46580  
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Introducing: \_\_\_\_\_

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An appointment has been made on (date & time): \_\_\_\_\_

Please evaluate the following:

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Crowding                        | <input type="checkbox"/> Openbite          | <input type="checkbox"/> Class II  |
| <input type="checkbox"/> Crossbite                       | <input type="checkbox"/> Excessive Overjet | <input type="checkbox"/> Class III |
| <input type="checkbox"/> Missing Teeth                   | <input type="checkbox"/> Impaction(s)      |                                    |
| <input type="checkbox"/> TMJ Evaluation with Dr. Ketcham |  |                                    |

Remarks:

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Please print, complete, and email to [info@ossfw.com](mailto:info@ossfw.com) or fax to 260-489-4853 (Fort Wayne office)  
OR 574-267-1405 (Warsaw office)

**Orthodontics**

**Aron Dellinger, D.D.S., M.S.D.**

**TMD Therapy**

**Bob Ketcham, D.D.S., M.S.D.**

