

Dr John Sambevski

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Patient Details	
Name:	_ DOB:
Address:	
Tel:	
Reason for Referral	
General orthodontic assessment	Impaction / Eruption problem
Crowding / Spacing	Class I / II / III malocclusion
Deep bite / Open bite	Habits
Anterior crossbite / Posterior crossbite	Missing teeth
Notes / Other:	
Referring Doctor	
Name:	
Practice Address:	
Email:	
Tel:	
Signature:	Date:



(02) 9982 1050



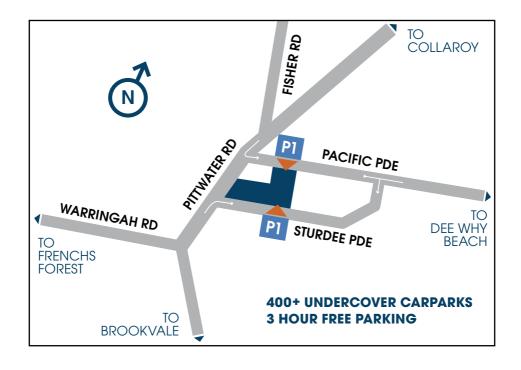
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Parking

Park on level P2 and take the lift to level 2



