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Introducing \_\_\_\_\_

Referred by Dr. \_\_\_\_\_ Today's Date \_\_\_\_\_

Responsible Party \_\_\_\_\_

Responsible Party Phone \_\_\_\_\_

Please evaluate for:  Interceptive/Mixed Dentition Treatment  
 Adolescent Treatment  Adult Treatment

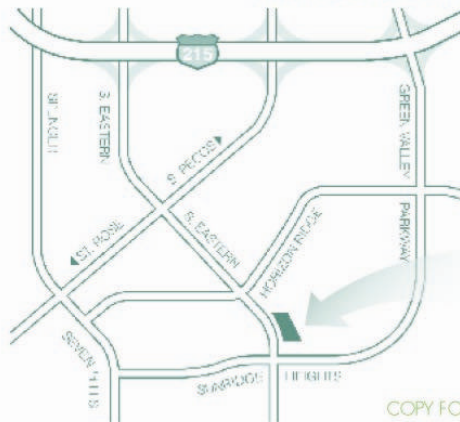
Special concerns \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Thank you for your interest in our office. We are pleased that your doctor has referred you for an orthodontic evaluation. Our goal is to provide you with the finest orthodontic care in an environment that is comfortable and friendly.

When you visit us for the first time, please have information available regarding any **medical conditions, medications, or insurance** that we may need to know about.

Please call us at **702.735.1010** to schedule an appointment for your initial examination.



**Stephen T. Chenin, DDS**  
**David A. Chenin, DDS, MSD**



We are proud to invite you to our office and look forward to meeting you.

COPY FOR PATIENT