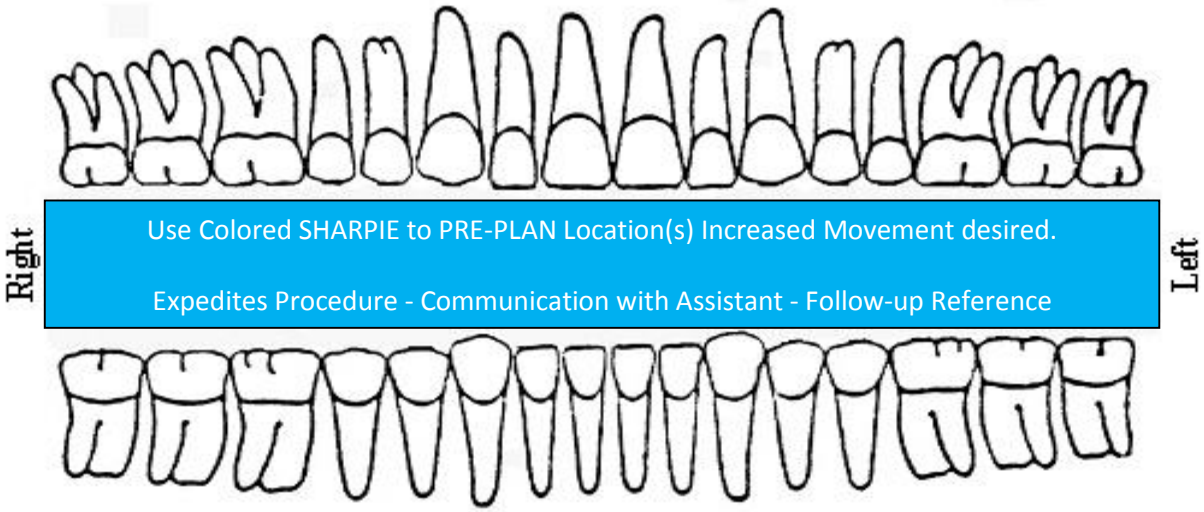
PATIENT NAME

PROCEDURE DATE:

REFERRED BY DOCTOR:

PROPEL ORTHODONTICS

MICRO-OSTEOPERFORATION SITES:



SCHEDULING:

Approximate Treatment dates: **May be repeated in 2-3 months (if needed)**

1: _____ **2:** _____ **3.** _____

Informed Consent: ☐

CHX Rinse: ☐

Advised no NSAID ☐

Notes:

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