DATE: ____/____/____

PATIENT NAME: _____

PARENT NAME: _____

ADDRESS: _____

_____

PHONE: _____EMERGENCY PHONE #_____

E. MAIL: _____

CIRCLE THE BEST WAY TO CONFIRM APPOINTMENTS.

PHONE/E.MAIL/OTHER_____ .

DATE OF BIRTH: _____/_____/_____

GENERAL DENTIST_____

REFERRED BY: _____

OFFICE USE ONLY

Medical / Dental Hx._____

First Ortho visit? _____. Like Braces? _____

Reason for consult (C.C.) _____

INITIAL DX

- Class I / II / III Division I / II malocclusion Subdivision
- Upper / Lower crowding / spacing
- Overbite / openbite
- overjet
- Maxillary midline offset to the
- Mandibular midline offset to the
- Lips apart / together at rest
- Early / Late eruption pattern
- Convex / Concave / Straight profile
- Gingiva appears normal
- Normal range of motion of TM joint
- Retrognathic / Prognathic mandible / maxilla

Preliminary Treatment Plan:

Est. Fee:_____