

Orthodontic Treatment Questionnaire

Name: (Last, First) _____ Date: _____

What seems to trouble you about your smile? (crooked teeth, spaces, overbite)?



Have you had braces before? Y ___ N ___ If Yes, when? _____

How important is it to you to have "Invisible" Orthodontics? _____

How important is the overall speed/time of your treatment? _____

Do you have a major social event coming up that we should take into account? (Wedding, Reunion etc.)

Y ___ N ___ If Yes, what is the event and the anticipated date for this event? _____

If enhancing your smile would require removal of permanent teeth, would you consider it?

Y ___ N ___ Maybe ___

If enhancing your smile would require a minor/major surgical plan, would you consider it?

Y ___ N ___ Maybe ___

When was your most recent dental check up/cleaning? _____

How often do you go for dental cleanings? _____

What is the name of the primary general dentist/ dental office taking care of you? _____

Phone: _____ Fax: _____ (to be filled by our staff if unknown)

Thank you for your time! We look forward to meeting you!

Doctor's Notes:
