thrive Dental

ORTHODONTIC CONSULT FORM

***Patient:** _____ **Age:**_____ **Date:** _____

***Dentist:** _____ ***Last Cleaning/Pending TX?**_____

***Has Pt seen Ortho before: Yes No**

***If yes, why did pt not start?**_____

***How did you hear about us**?_____

OH: Good:_____ Fair:_____ Poor:_____

Facial Profile: Convex:_____ Concave:_____

TMJ: Clicking/Popping Crepitus WNL

Classification

Right Molar:_____ Left Molar: _____

Right Canine:_____ Left Canine: _____

Dentition: Primary:_____ Mixed:_____ Permanent:_____

	R **Permanent** L		R **Primary** L	
Upper	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	E D C B A	A B C D E
Lower	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	E D C B A	A B C D E

Arch Length: *Upper* Crowding:_____ *Lower* Crowding: _____

Spacing:_____ Spacing:_____

Overbite: _____mm / % **Overjet:** _____mm **Open bite:** _____mm

Cross bites: _____ **Midlines:**_____mm

Pathological findings:_____

Habits: _____ **Frenum Involvement**:_____

Treatment Time (Appliances/Extractions?): _____

Clear Aligner eligible (Y/N): _____ **Doctor name:**_____

Treatment Coordinator Name: _____ **Office**: _____