braces by dr. poidmore
orangevale | folsom

INTRODUCING:

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ EMAIL ADDRESS: _____

FOR AN ORTHODONTIC EVALUATION:

REFERRED BY: _____ DATE: _____

DATE OF LAST CLEANING: _____ DATE OF LAST VISIT (IF DIFFERENT): _____

☐ ALL NECESSARY PRE-ORTHODONTIC WORK IS COMPLETED - PATIENT MAY BEGIN ORTHODONTIC TREATMENT

☐ THE FOLLOWING DENTAL WORK MUST BE COMPLETED PRIOR TO STARTING ORTHODONTIC TREATMENT:

_____

DATE OF SCHEDULED PENDING DENTAL WORK:_____

PRIMARY CONCERNS

☐ CROWDED TEETH ☐ SPACED TEETH ☐ MISSING TEETH ☐ PROTRUSIVE TEETH

☐ CROSSBITE ☐ DEEP OVERBITE ☐ OPEN BITE ☐ FACIAL GROWTH PROBLEM

☐ TMJ DYSFUNCTION ☐ UNDERBITE ☐ TOOTH ALIGNMENT FOR CROWN & BRIDGE ☐ OTHER:_____