Name_____ **Date** _____

What brings you into our office? _____
(i.e. Consult / Concern, Second Opinion)

Have you seen an orthodontist prior to this visit for a consult? If so, when and where? _____

_____

Who Suggested that you might need orthodontic treatment? _____

What do you want to improve most about your smile? _____
(i.e. Bite, Midline, Crowding, Spacing, Jaw Position)

How did you hear about us? _____
(i.e. Dentist Referral, Family/Friend Recommended, GoogleSearch, Social Media)

Who is your dentist? _____

What type of orthodontic treatment are you interested in? _____
(i.e. Invisalign, Traditional Braces, Clear Braces, Maintenance/Retainers)

Do you have a goal for treatment time frame? If so, when? _____
(i.e. Treatment done by Graduation, Wedding or Special Event)

For future appointments, would you be interested in morning appointments? _____