Smile Ft.Worth

Orthodontic Consultation Information

Patient information Date_____

LEGAL NAME _____

NAME YOU WISH TO BE CALLED_____

SOCIAL SECURITY #_____ DRIVERS LICENSE_____

SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

IF A MINOR, PARENT OR GUARDIAN NAME_____

STREET ADDRESS_____CITY_____ZIP_____

HOME PHONE: _____CELL:_____BUSINESS:_____

EMAIL _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT HERE? ☐ Yes ☐ No If yes, name_____

MAY WE THANK SOMEONE FOR REFERRING YOU TO US?_____

Would you like to receive appointment confirmations by:

Phone (list preferred number) _____ Text: ☐ Yes ☐ No Email: ☐ Yes ☐ No

So that we may serve you optimally, please answer the following questions regarding your orthodontic history:

1. Have you worn braces previously? ☐ Yes ☐ No
2. If yes, what year(s) and for how long?_____
3. If no, have you been diagnosed previously as needing orthodontic treatment? ☐ Yes ☐ No
4. What is your chief concern with your smile (please be as specific as possible)_____

   _____

   _____
5. What do you hope to accomplish by straightening your teeth? What are your goals for your smile _____

   _____

   _____
6. Are you interested in conventional braces? ☐ Yes ☐ No ☐ Clear brackets ☐ Invisalign
7. Have you ever been told you are not a candidate for Invisalign? ☐ Yes ☐ No
8. Is there a time frame in which you would like to be completed with your orthodontic treatment? _____

   _____