



First Name: _____ Last name: _____ Personal code: _____

1. Main complaints:

- Aesthetics Function Incorrect bite Joint pain Dental recessions
- Face or profile Other: _____ Dentist referral (Name of dentist): _____

Write in your own words: What you don't like, what you would like to improve, if and why you were referred to us:

2. Treatment priorities:

- Both jaws Only upper Only lower

Write in your own words: what you expect from the treatment and what are your concerns

3. Have you had orthodontic treatment before?

- Yes No

If yes, please provide brief information of what you remember (When, how long, what was done):

4. Please right down any limitations or special requests worth noting (Personal and/or medical):

5. How did you find us?

- Friend or Family: _____ Dentist or Clinic referral

Name: _____

Name: _____

- Internet:
 - Facebook
 - Instagram
 - Google search
 - Other: _____

Other: _____