ANDERSON ORTHODONTICS

*creating confident smiles*

# Preliminary Orthodontic Evaluation

Introducing: ________________________________ DOB ____________

Address and Phone: ________________________

________________________

________________________

Patients Chief
Complaint: __________________________________________________

__________________________________________________________

Pertinent Dental
History: ____________________________________________________

Orthodontic Findings:

- Molar Classification: I ____ II ____ III ____
- Skeletal Disharmonies: Max ___ Mand ___ Vertical ___ Transverse ___
- Crossbite: Anterior ____ Posterior ____
- Missing Teeth: Yes ___ No ___
- Impacted Teeth: Yes ___ No ___
- Oral Habit: Yes ___ No ___
- Oral Hygiene Excellent ___ Good ___ Fair ___ Poor ___

Other Concerns: _____________________________________________

__________________________________________________________

Referred By: ______________________________ Date: ______________

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