Patientõs Name: _____ Date: _____

Patient Goals

Please list your treatment goals below. This will help Dr. Steckel better plan your orthodontic treatment.
(What you wish we could change about your teeth, smile or profile. Ex: straight teeth, correct overbite)

1. _____

2. _____

3. _____

Please Circle Appliance Preference

Fixed Braces	**Invisalign**	**Retainer**	**None**
ñColorsò		Fixed	
Steel		Removable	
Clear (Adult only)		Trutain	

What is the status of the patientõs dental health? Σ Excellent Σ Good Σ Poor

PATIENT PROFILE

Does the patient follow directions well? Σ Yes Σ No
Does the patient have learning disabilities or need extra help with instructions? Σ Yes Σ No
Is the patient sensitive or self-conscious about teeth? Σ Yes Σ No

When was your last dental cleaning? _____(month/year)

Tell us about the patientõs routine for cleaning their teeth? How often? Do they floss?

_____

What are the patientõs three most favorite foods? 1. _____

2. _____

3. _____

Is it a high priority to keep your teeth or can some be removed to relieve crowding?

_____

Do you anticipate that you will be relocating during the next two years? Σ Yes Σ No

If yes, where: _____

Patient/Parent Signature:
_____

Dr. Stephanie Steckel ŏ 42 Hiawatha Lane ŏ Dover, DE 19904 ŏ 302-672-7776
www.doverorthodontics.com