Susan Carpenter
ORTHODONTIST

Registered Specialist Orthodontist

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Treatment Expectations Form - Adults

In order for us to provide the best possible care for you, and be fully informed of your requirements and expectations, please complete the following questions and return to us with your Medical History Form at your examination appointment. Thank you.

Name ______________________________

What is the reason for your visit today? (please tick one or more)

- ☐ Referred by your dentist
- ☐ Concerned about your teeth or bite

When was your last dental check up? (approx) ______________________________

Smile and teeth appearance : what do you not like about your teeth?

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Smile and facial appearance : what do you not like about your smile or facial appearance?

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Have you had any previous orthodontic treatment or orthodontic opinions? If yes, what was the name of the orthodontist? **Yes / No**

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Do you have any discomfort with your teeth or jaws? **Yes / No**

Have you been advised of any missing or extra teeth? **Yes / No**

Have you any implants, crowns or bridges? **Yes / No**

Have your wisdom teeth been extracted? **Yes / No**

Have you had any significant trauma to your baby or adult teeth? **Yes / No**

Do you have any questions or information that may be helpful to us?

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