

PERIODONTAL AND RESTORATIVE STATUS FOR ORTHODONTIC TREATMENT PLANNING

FROM: _____ REGARDING PATIENT: _____

DATE: _____

PLEASE PROVIDE US WITH THIS INFORMATION AND ANY OTHER CONSIDERATIONS WHICH YOU WOULD LIKE TO HAVE INCLUDED IN TREATMENT PLANNING:

PERIODONTAL STATUS

1. EXCESSIVE TOOTH MOBILITY: _____
2. AREAS OF INFLAMMATION OR BLEEDING ON PROBING: _____
3. CURRENT FREQUENCY OF DENTAL CLEANINGS: ___ 3 MONTHS ___ 4 MONTHS ___ 6 MONTHS
4. HAS THE PATIENT BEEN KEEPING REGULAR HYGIENE APPOINTMENTS? ___ YES ___ NO
5. PLEASE RATE THE PATIENT'S COMPLIANCE WITH ORAL HYGIENE INSTRUCTIONS:
POOR 1 2 3 4 5 EXCELLENT
6. WOULD YOU LIKE TO INCREASE THE FREQUENCY OF CLEANINGS DURING ORTHODONTIC TREATMENT?
___ NO ___ YES IF YES HOW OFTEN? _____
7. ARE THERE ANY CONTRAINDICATIONS TO _____ UNDERGOING ORTHODONTIC TREATMENT?
___ NO ___ YES
8. PLEASE ATTACH A FULL MOUTH PROBING IF AVAILABLE.

RESTORATIVE CARE

1. DATE OF LAST CLEANING/CHECK-UP? _____
2. IF PERMANENT EXTRACTIONS WERE TO BE RECOMMENDED, WOULD YOU WANT TO PERFORM THEM?
___ YES ___ NO
IF NOT, WHERE WOULD YOU LIKE THE REFERRAL TO BE ADDRESSED FOR EXTRACTIONS?

3. IS THERE ANY OUTSTANDING RESTORATIVE WORK TO BE COMPLETED?
PRIOR TO ORTHODONTIC TREATMENT? _____

THE DATE THIS WORK IS SCHEDULED FOR? _____

AFTER COMPLETION OF ORTHODONTIC TREATMENT? _____

4. PLEASE ATTACH A RESTORATIVE TREATMENT PLAN IF APPROPRIATE.

COMPLETED BY: _____ DATE: _____