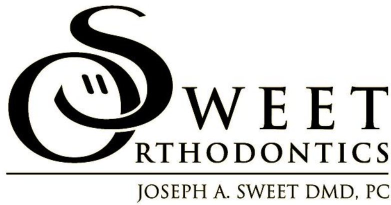

Patient Name: ____________________________ **Date:** ____________________

Are you interested in: (Please indicate all that apply)
[ ] Information
[ ] Treatment at this time
[ ] Clarification of previously received or conflicting information

If your child's teeth were to be changed, how would you like them changed?
[ ] Upper teeth Forward/Backward
[ ] Lower teeth Forward/Backward
[ ] Upper teeth up because gums show too much
[ ] Close spaces Upper/Lower
[ ] Straighten crowded teeth Upper/Lower
[ ] Improve the appearance of chipped/cracked/stained/dark/pointed teeth

Do you realize that growth has a strong influence on the success of orthodontic treatment?
Yes _____ No _____

Is it likely that your son or daughter will be an early maturer or late maturer?
Early _____ Late _____

How tall do you think this child will be when growth is completed? ____ ft ____ inches

Are you aware that orthodontic treatment can to some extent alter facial appearance?
Yes _____ No _____

If any features of the face could be changed, what would you like to see:
[ ] Upper lip Forward/Backward
[ ] Lower lip Forward/Backward
[ ] Upper jaw Forward/Backward
[ ] Lower jaw Forward/Backward
[ ] Chin Larger/Smaller
[ ] Nose Larger/Smaller/Different Shapes

Would you prefer that facial appearance <u>NOT</u> be discussed in front of your child?
Yes _____ No _____

Is there any significant family history of jaw or teeth problems?
Yes _____ No _____ if yes, please explain: ____
____

Are you interested in improving the appearance of the teeth at this time even if more treatment will be needed later? Yes _____ No _____

____
Signature Relationship to Patient