



Date of Birth \_\_\_//\_\_\_//

## Orthodontic Related Dental Health History For Orthodontic Consultation

We would like to know about why you are seeking Orthodontic Treatment Options Filling in this questionnaire as fully as possible will make it easier to meet your expectations. The more information you give us the better! Have you had an orthodontic consultation/treatment in the last 2 years? Yes/No \_\_\_//\_\_\_// If yes then please give the approx date: If yes then did you get a written Treatment Plan and quote Yes/No Your Concerns Please describe below any concerns you have about your teeth. Please describe any problems you wish to correct Your Expectations We want to meet your expectations. So please describe what would be a favourable outcome to your presenting problem. The more information you give the easier it will be to meet your expectations.

## The Hub Dental Practice



Date of last Dental Examination	////
Date of last Dental Hygienist visit	////
Name/Location of your current/previous dentist	
Did you complete all the suggested treatment at your last checkup?	Yes/No
If not then Why not?	
Please describe below any other information you feel is important.	
Name	Date of Rirth // //