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greentree orthodontics

Introducing _____ Date _____

Parent Name _____ Adult Patient

Phone _____ DOB _____

Date of last hygiene visit _____ Date of Last Exam _____

Preferred hygiene freq. _____ 3 - 4 months ☐ 6 months ☐

Cleared periodontally to start orthodontics? ☐ Yes ☐ No iCAT CBCT Scan only

Has all pre-orthodontic dental work been completed? ☐ Yes ☐ No Referring Dentist _____

Is it permissible to begin treatment? ☐ Yes ☐ No

If no, the following dental work needs to be completed/comments:

White - Patient's Copy Yellow - Referring Doctor's Copy Pink - please send to GreenTree Orthodontics