

WELCOME TO OUR OFFICE

Patient's Name: _____

Previous Orthodontist's Name: _____

Address: _____

City, State: _____

Telephone Number: _____

Reason(s) for treatment: _____

Treatment started (month, year): _____

Original estimated time to complete treatment: _____

Were permanent teeth extracted? _____

If yes, please list: _____

Did you wear or are you wearing a headgear, elastics, or a removable appliance? _____

If yes, please describe: _____

Treatment progress (check one): ___ ahead of schedule ___ on schedule ___ delayed

Total treatment fee: _____

Orthodontic insurance (list company name and coverage): _____

Initial Fee: _____

Monthly payment: _____

Amount paid to date: _____

We would appreciate any comments or concerns to help us in continuing the orthodontic care.

DR. LILI HORTON