Orthodontic assessment form

Patient details	
Name	Referrer:
Address	Reason for referral
Tel Contact:	
Date of birth:	
History	
Patient's complaint	Habits
	Growth status
Motivation	Medical history
Dental history (including trauma and previous treatments)	Socio-behaviour factors
Extra-oral examination	
Anteroposterior	Smile aesthetics
Vertical	Soft tissues
Transverse	TMJ
Intra-oral examination	
Teeth present:	Lower arch
Oral hygiene	
Periondontal health	Upper arch
Tooth quality	
Teeth in occlusion	
Incisor relationship	*Molars* Right Left
Overjet = mm	*Canines* Right Left
Overbite	Crossbites
Centrelines	Displacements