# PERIODONTAL AND RESTORATIVE STATUS FOR ORTHODONTIC TREATMENT PLANNING

**FROM:** **REGARDING PATIENT:**

**DATE:**

PLEASE PROVIDE US WITH THIS INFORMATION AND ANY OTHER CONSIDERATIONS WHICH YOU WOULD LIKE TO HAVE INCLUDED IN TREATMENT PLANNING:

## PERIODONTAL STATUS

1. EXCESSIVE TOOTH MOBILITY: _____
2. AREAS OF INFLAMMATION OR BLEEDING ON PROBING: _____
3. CURRENT FREQUENCY OF DENTAL CLEANINGS: ☐ 3 MONTHS ☐ 4 MONTHS ☐ 6 MONTHS
4. HAS THE PATIENT BEEN KEEPING REGULAR HYGIENE APPOINTMENTS? ☐ YES ☐ NO
5. PLEASE RATE THE PATIENT'S COMPLIANCE WITH ORAL HYGIENE INSTRUCTIONS:

   ☐ POOR ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ EXCELLENT
6. WOULD YOU LIKE TO INCREASE THE FREQUENCY OF CLEANINGS DURING ORTHODONTIC TREATMENT?

   ☐ NO ☐ YES IF YES HOW OFTEN? _____
7. ARE THERE ANY CONTRAINDICATIONS TO _____ UNDERGOING ORTHODONTIC TREATMENT?

   ☐ NO ☐ YES
8. PLEASE ATTACH A FULL MOUTH PROBING IF AVAILABLE.

## RESTORATIVE CARE

1. DATE OF LAST CLEANING/CHECK-UP? _____
2. IF PERMANENT EXTRACTIONS WERE TO BE RECOMMENDED, WOULD YOU WANT TO PERFORM THEM?

   ☐ YES ☐ NO

   IF NOT, WHERE WOULD YOU LIKE THE REFERRAL TO BE ADDRESSED FOR EXTRACTIONS?

   _____
3. IS THERE ANY OUTSTANDING RESTORATIVE WORK TO BE COMPLETED?
   PRIOR TO ORTHODONTIC TREATMENT?_____

   _____

   THE DATE THIS WORK IS SCHEDULED FOR? _____

   AFTER COMPLETION OF ORTHODONTIC TREATMENT?_____

   _____
4. **PLEASE ATTACH A RESTORATIVE TREATMENT PLAN IF APPROPRIATE.**

   COMPLETED BY: _____ DATE: _____