

ORTHODONTIC ASSESSMENT FORM

Date of assessment:

Orthodontist's name:

Patient's name:

Date of birth:

Address:

Patients complaint:

Willingness for treatment:

SKELETAL ASSESSMENT

Anteroposterior:

Vertical:

Transverse:

TMJ

SOFT TISSUE ASSESSMENT

Lip tonicity:

Lip competence:

Smile aesthetics:

Tongue thrust: yes/no

INTRA-ORAL ASSESSMENT

Teeth present:

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Oral hygiene:

Periodontal condition:

Caries:

Teeth of poor prognosis:

LOWER ARCH:

UPPER ARCH:

TEETH IN OCCLUSION:

Incisor classification:

Overjet:           mm

Overbite:

Buccal segments Right side

Canines:

Molar:

Buccal segments Left side

Canines:

Molar:

Centrelines: -----|-----

Crossbites: -----|-----

SUMMARY: