New Patient Intake Screening Questionnaire

Date:_____ Name_____ Phone #_____

Have you scheduled an in-office appointment ? Y/N Date:_____

What is your main concern?

- Spacing
- Crowding
- Bite

Other:_____

• Have you ever had Braces or Clear Aligners before? Y/N

• Are you interested in Clear Aligners or Braces ?

If Braces, what type Braces are you interested in?

- Same Day Braces
- Fast Braces
- Hidden Braces
- Tooth Colored Braces
- Traditional Metal Braces

• Do you have healthy Teeth and Gums? Y/N Last Checkup_____

• What is most important to you? (rate 1-4 with 1 most important)

Cosmetics:___Comfort: ____Treatment Time:____ Cost:_____

• Do you have Dental insurance that covers orthodontic treatment: Y/N

• Amount: $_____

Interested in

- Pay in Full Discounts

- Low monthly Payments, or qualifying for NO Down Payment
- NO Interest payment plans?

  Desired Down Payment $_____

  Desired Monthly Payment $_____

- What is your overall budget for Treatment?_____

Comments:_____
_____
_____

Staff Name:_____Date:_____