PONTE VEDRA
ORTHODONTIC SOLUTIONS

PATIENT NAME: _____ DATE: _____

REFERRED BY: _____ PHONE: _____

AREAS OF CONCERN:

- ☐ PHASE I / INTERCEPTIVE CARE (EARLY GROWTH/ERUPTION)
- ☐ PRE-PROSTHETIC / IMPLANT SPACE MANAGEMENT
- ☐ ORTHOGNATHIC SURGERY / SKELETAL ASYMMETRY
- ☐ AIRWAY / MOUTH BREATHING / SNORING
- ☐ OPEN BITE / ORAL HABITS (THUMB, TONGUE)
- ☐ SLEEP APNEA / CPAP INTOLERANCE
- ☐ IMPACTED / ECTOPIC / MISSING TEETH
- ☐ CROSSBITE (ANTERIOR OR POSTERIOR)
- ☐ TMJ / FUNCTIONAL CONCERNS
- ☐ CROWDING / SPACING
- ☐ OVERBITE / OVERJET / UNDERBITE
- ☐ OTHER: _____

DENTAL HISTORY:

- ☐ DATE OF LAST CLEANING AND CHECKUP _____
- ☐ RESTORATIVE WORK NEEDED

AVAILABLE IMAGES OR STUDIES: ☐ PAN ☐ CEPH ☐ CBCT ☐ SLEEP STUDY

ADDITIONAL COMMENTS:

_____

_____

_____

_____

HUMBERTO ESPINOSA, DDS

ADVANCED AIRWAY ORTHODONTIC CARE

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Request a Consultation
Get Directions