

Diagnostic Services – Doctor Profile

SOUTHWEST OFFICE: 9129 Lurline Ave. Chatsworth, CA 91311 • Phone 800.423.3270 Fax 818.341.4684 • www.ApplianceTherapy.com

Doctor's Name: _____ Date: _____

Office Phone #: _____ License #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

In order for us to accurately suggest the type of therapy that is needed for your patients,
please fill out the following information.

Please list any courses, seminars and techniques that you have completed: (This information will help us select the appropriate treatment approach)

Describe your level of orthodontic experience:

I prefer to treat my patients with: Removable Appliances Fixed Appliances I am comfortable with both approaches

I have used the following appliances / techniques in my practice:

- | | |
|--|--|
| <input type="checkbox"/> Simple Space Maintenance Appliances | <input type="checkbox"/> Full Arch Appliances (Bands and direct bond brackets) |
| <input type="checkbox"/> Simple Minor Tooth Movement | <input type="checkbox"/> Individual Tooth Movement Appliances |
| <input type="checkbox"/> Habit Appliances | <input type="checkbox"/> Adults |
| <input type="checkbox"/> Regaining Space Appliances | <input type="checkbox"/> Children |
| <input type="checkbox"/> Closing Space Appliances | <input type="checkbox"/> Splints |
| <input type="checkbox"/> Crossbite Appliances | <input type="checkbox"/> Bruxism |
| <input type="checkbox"/> Arch Development Appliances: | <input type="checkbox"/> T.M.J. |
| <input type="checkbox"/> Schwarz | <input type="checkbox"/> Interim Appliances |
| <input type="checkbox"/> Sagittal | <input type="checkbox"/> Partials |
| <input type="checkbox"/> MemRx | <input type="checkbox"/> Bridges |
| <input type="checkbox"/> Fixed Rapid Palatal Expanders | <input type="checkbox"/> Periodontal Appliances |
| <input type="checkbox"/> Wilson 3D Appliances | <input type="checkbox"/> Implant Appliances |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Surgical Stents |
| <input type="checkbox"/> Functional Appliances: | <input type="checkbox"/> Temporary Implant Appliances |
| <input type="checkbox"/> Bionator | <input type="checkbox"/> Final Retainers |
| <input type="checkbox"/> Twin Block | <input type="checkbox"/> Snoring and Sleep Apnea Appliances |
| <input type="checkbox"/> Tandem | <input type="checkbox"/> Mouthguards |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> A.R.S. Technique | |

How long have you been using appliance therapy to control and direct your treatment? _____