second opinion®

Diagnostic Member of The Appliance Therapy Group

Doctor's Profile

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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)

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Describe your level of orthodontic experience: ____________________

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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:

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

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

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