PATIENT INFORMATION

Date _____ Family Dentist _____ B K S

Patient's Name (First, Middle, Last) _____ M F _____ Age _____ Birthdate _____

Mailing Address Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Cell Phone for Text Reminders: _____

School _____ Grade _____ Interests _____

Siblings (Name and Age) _____

Email for Reminders _____

RESPONSIBLE PARTY INFORMATION

Custodial Parent's Name (First, Last) _____ Marital Status _____

Mailing Address Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Birthdate _____ Relationship to Patient _____

Employer _____ Number of Years Employed _____

Parent/Spouse's Name (First, Last) _____ Marital Status _____

Mailing Address Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Birthdate _____ Relationship to Patient _____

Employer _____ Number of Years Employed _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____ Member ID# _____

Insurance Company _____ Group No. _____ Birthdate _____

Insurance Company Address _____ Insured's Soc. Sec. # _____

Do you have dual coverage? Yes No If Yes:

Insured/s Name _____ Member ID# _____

Insurance Company _____ Group No. _____ Birthdate _____

Insurance Company Address _____ Insured's Soc. Sec. # _____

Chief Concern

Date of last dental visit?

Past dental facial trauma	Yes	No	Major accidents or surgery involving the face, neck, mouth or teeth?		Teeth broken, loosened or knocked out?		Missing teeth	
Jaw joint problems:	Yes	No	Locking	Pain	Noise	Discomfort Opening or closing	Frequent headaches	Clenching or grinding
Oral problems	Yes	No	Canker/cold sores	Swollen/bleeding gums	Hepatitis	Habits Thumb/finger	Speech	Mouth Breathing Day ☐ Night ☐
Difficulty chewing or swallowing food?	Yes	No	Previous orthodontic treatment/consultation? Yes No			Orthodontist	Outcome	
Siblings had orthodontics?	Yes	No	Name/Stage of treatment:					
Parents had orthodontics?	Yes	No	Mother Father		Orthodontist	Results	Does patient's stature, teeth or mouth resemble: M F Neither	

Does anyone else in the family have a similar dentofacial condition:
Crowded, retruded or protruded teeth, protruding lower jaw, receding chin

MEDICAL HISTORY

Present Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Physician:

Hospitalized in past 3 yrs?	Yes	No	Operations	Tonsils & Adenoids	Other
Chronic diseases?	Yes	No	(lungs, liver, kidney, heart, etc.)		
Presently under the care of a physician?	Yes	No	(diabetes, hepititis, high/low blood pressure, etc.)		
Presently under medication?	Yes	No	Medication:		Prescribed for:
Allergies:	Yes	No	Describe:		
Complications to previous treatment	Yes	No	(excessive bleeding, fainting, drug reaction?)		
Does the patient smoke?	Yes	No	(Or use any tobacco products) Yes No		

Any disease, condition or problem the orthodontist should know about?

Has the patient ever had any of the following conditions?

- ☐ AIDS/HIV +
- ☐ Asthma
- ☐ Epilepsy
- ☐ TB
- ☐ Venereal disease
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Congenital Heart Defect
- ☐ Hemophilia
- ☐ Emotional Problems

Signature (Parent's/Guardian's signature if minor) _____

Whom may we thank for referring you to our office? _____

Classification	Dental	Dentition Now		Date _____
Skeletal _____	R _____ L _____	R	L	B S

Diagnostic Factors:

M = Missing
F = Fractured
S = Small
B = Bridges
U = Underdeveloped
C = Crown
P = Peg
I = Impacted

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Soft Tissue: (Add'l Complicating Factor:)

Profile: Retro _____ Ortho _____ Prog _____
Conv _____ Str _____ Conc _____
Lips: Norm _____
Incomp at rest _____
Lower everted on lip closure _____
Mentalis: Norm _____ Str on lip closure _____
Tongue: Norm _____ Thrust _____ Lg _____
Frenum: Norm _____ Low _____ Thick _____
Habits: None _____ Thumb _____ Finger _____
Tongue _____ Lip _____
Airway: Adequate _____
Mouth Breather due to nasal resistance _____
Mouth Breather due to skeletal pattern _____
Physical: Ecto _____ Meso _____ Endo _____

Dental:

Overjet: Norm _____ Excess _____ Neg _____
mm _____
Overbite: Norm _____ Excess _____ Neg _____
mm _____
Midline: Coin _____
Max R ____ mm L ____ mm
Mand R ____ mm L ____ mm
Crossbite: Ling _____
Bucc _____

Arch Length:
Max: Insuf. _____ Suff _____ Spaced _____
Mand: Insuf. _____ Suff _____ Spaced _____

Arch Form:
Max: Constr _____ Normal _____ Wide _____
Mand: Constr _____ Normal _____ Wide _____

T.M. Joints

	R	L		Strt.	Dev.		R	L
	Asymp			POO		Crepitus		
CHART_____	Pain			Non Painful		Click		

Periodontal Status

Hygiene: g _____ f _____ p _____
Gingiva: WNL _____ Infl _____
MG _____ PD _____
Bleeding on Probing: y _____ n _____
Perio eval rec: y _____ n _____

pockets	B																
	L																
recession																	
		8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
pockets	B																
	L																
recession																	

Notes:

Date	This Appt	Next Appt		Date	This Appt	Next Appt