

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ AGE: _____
 PREFERRED NAME: _____ MALE FEMALE
 ADDRESS: _____ PHONE: (____) _____ CELL: (____) _____
 CITY: _____ STATE: _____ ZIP: _____ SCHOOL/EMPLOYER: _____
 HOBBIES/SPECIAL INTERESTS: _____
 NAME OF GENERAL DENTIST: _____ PHONE: (____) _____
 NAME OF OTHER FAMILY MEMBERS TREATED HERE: _____
 WHOM MAY WE THANK FOR REFERRING YOU? _____

SPOUSE'S INFORMATION

NAME: _____
 BIRTHDAY: _____ SS#: _____ ADDRESS: _____
 EMAIL: _____ PHONE: (____) _____ CELL: (____) _____
 EMPLOYER: _____
 EMERGENCY CONTACT: _____ PHONE: (____) _____

PATIENT DENTAL/MEDICAL HISTORY

WHY HAVE YOU COME TO THE ORTHODONTIST TODAY? _____
 DO YOU LIKE YOUR SMILE? _____ YES NO
 ARE YOU CURRENTLY IN PAIN? _____ YES NO
 YOUR CURRENT DENTAL HEALTH IS: _____ GOOD FAIR POOR
 HAVE YOU EVER HAD ANY SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK?
 _____ YES NO
 HAVE YOU EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT? _____ YES NO
 DO YOUR GUMS EVER BLEED? _____ YES NO
 HOW MANY TIMES A WEEK DO YOU FLOSS? _____
 HOW MANY TIMES A WEEK DO YOU BRUSH? _____
 TYPES OF BRISTLES: _____ HARD MEDIUM SOFT
 DO YOU HAVE A PERSONAL PHYSICIAN? _____ YES NO
 NAME: _____ PHONE #: _____
 YOUR CURRENT PHYSICAL HEALTH IS: _____ GOOD FAIR POOR
 ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR? _____ YES NO
 EXPLAIN: _____
 ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____ YES NO
 LIST: _____

YES	NO	YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DEFECT
<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS/EPILEPSY
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL BLEEDING
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	HEARING IMPAIRMENT
<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	ANY OPERATIONS
<input type="checkbox"/>	<input type="checkbox"/>	HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>	ANY STAYS IN HOSPITAL
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY/LIVER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	HANDICAPS/DISABILITIES
<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO ANY DRUGS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF SCARLET FEVER
<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY/LIVER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL VALVES
<input type="checkbox"/>	<input type="checkbox"/>	SHINGLES	<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY/PACEMAKER
<input type="checkbox"/>	<input type="checkbox"/>	FEVER BLISTER	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE
<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL BONES/JOINTS
<input type="checkbox"/>	<input type="checkbox"/>	ULCERS/COLITIS	<input type="checkbox"/>	<input type="checkbox"/>	SEVERE/FREQUENT HEADACHES
<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	HI/LOW BLOOD PRESSURE
<input type="checkbox"/>	<input type="checkbox"/>	SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DRUG/ALCOHOL ABUSE
<input type="checkbox"/>	<input type="checkbox"/>	PROSTHESIS	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TRANSFUSION
<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA/RADIATION TX
OTHER: _____		<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	

FOR WOMEN ONLY

ARE YOU TAKING BIRTH CONTROL PILLS? YES NO
 ARE YOU PREGNANT? YES NO WEEK #: _____
 ARE YOU NURSING? YES NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	ERYTHROMYCIN	<input type="checkbox"/> YES <input type="checkbox"/> NO
CODEINE	<input type="checkbox"/> YES <input type="checkbox"/> NO	TETRACYCLINE	<input type="checkbox"/> YES <input type="checkbox"/> NO
LATEX	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER: _____	
PENICILIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE: _____ DATE: _____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____
 INSURANCE PHONE: _____
 GROUP/POLICY #: _____
 INSURED'S NAME: _____
 RELATIONSHIP TO PATIENT: _____
 INSURED'S DOB: _____
 SS#/ID#: _____
 INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____
 INSURANCE PHONE: _____
 GROUP/POLICY #: _____
 INSURED'S NAME: _____
 RELATIONSHIP TO PATIENT: _____
 INSURED'S DOB: _____
 SS#/ID#: _____
 INSURED'S EMPLOYER: _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

SIGNATURE: _____ DATE: _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

SIGNATURE: _____ DATE: _____

OFFICE USE ONLY

PROFILE	MANDIBLE	SYMMETRY	LIPS AT REST	FACIAL HEIGHT
115 convex	118 mesognathic	000 symmetrical	058 together	121 normal
116 concave	119 retrognathic	039 mandible to RT	059 apart	122 short
117 straight	120 prognathic	039 mandible to LT	060 trapped	123 long

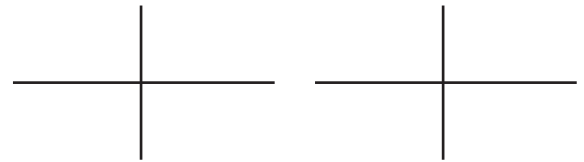
MOLAR CLASS	CROWDING	SPACING	MAX MIDLINE	MAND MIDLINE
001 Class I	007 none upper	005 upper	000 normal	000 normal
002 Class II div 1 RL	008 none lower	019 diastema	040 to RT	042 to RT
003 Class II div 2 RL	015 upper sl mod sev	006 lower	041 to LT	043 to LT
004 Class III	015 lower sl mod sev			

TMJ SYMPTOMS	MANDIBULAR MOVEMENT	PERIO	RANGE OF OPENING
051 none R,L	036 mod 1-3mm	064 healthy	110 normal _____ mm
360 neg/bad test	037 excess 4-6mm	055 gingivitis	111 limited _____ mm
062 click/pop R,L	038 severe 7+	057 recession	
opening, closing, lateral	039 end-end	056 periodontitis	
		055 crepitus R,L	
		056 condylar pain R,L	
		057 muscle pain	

DENTAL LEVEL 000 primary 000 secondary 000 mixed

TEETH PRESENT:

TEETH MISSING:



OVERBITE **OVERJET** **CROSSBITE** **ENAMEL DEFECTS**

025 mod 25-75%	036 mod 1-3mm	026 anterior cross	096 decalcification
022 deep 75-100%	037 excess 4-6mm	shape	097 defects
021 100% +	038 severe 7+	028 posterior	098 attrition
024 openbite	039 end-end	029 max buccal	379 abfractions
027 edge-edge			

COMMENTS: _____

