

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 OF PARENT/GUARDIAN: _____ 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 OF PARENT/GUARDIAN: _____ 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

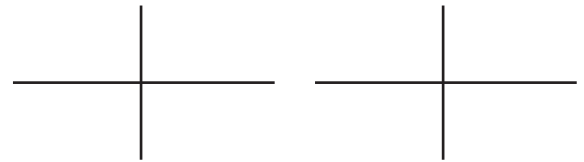
MOLAR CLASS	CROWDING	SPACING	MAX MIDLINE	MAND MIDLINE
001 Class I	007 none upper	005 upper	000 normal	000 normal
002 Class II div 1 RL	008 none lower	019 diastema	040 to RT	042 to RT
003 Class II div 2 RL	015 upper sl mod sev	006 lower	041 to LT	043 to LT
004 Class III	015 lower sl mod sev			

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: _____

