Patient's Name: Last	First	MI	Nickname
Birthdate	Age	Sex	Soc Sec #	Sports, Hobbies, Habits
Patient Street Address	City	State	Zip
Cell Phone	Email	Home Phone
Employer	Occupation	Business Phone

Spouse's Name	Birthdate	Soc Sec #
Spouse's Employer	Business Phone	Cell Phone

MARITAL STATUS: □ Single □ Married □ Divorced □ Separated

Children (Names and birthdates):_____

_____

_____

Have children had orthodontic treatment? □ Yes □ No

Doctors Name_____

Who referred you to our office?_____

Is Dental Insurance Available? □ Yes □ No

Orthodontic Coverage? □ Yes □ No

Primary Policy Holder: _____

Carrier: _____

Policy #: _____ Group #: _____

Person Financially Responsible:_____

DENTAL HISTORY

Dentist: _____ City: _____

Face, mouth, or tooth injuries?_____ □ Yes □ No

Any teeth removed (baby or permanent)? _____ □ Yes □ No

Jaw fractures, cysts, or mouth infections? _____ □ Yes □ No

"Dead teeth" or root canal treatment?_____ □ Yes □ No

Any extra teeth or congenitally missing teeth? _____ □ Yes □ No

Tooth grinding or clenching? _____ □ Yes □ No

Problems chewing or opening jaw? _____ □ Yes □ No

Family history of jaw size imbalance? _____ □ Yes □ No

Last dental visit: _____ Last dental X-ray: _____

Is patient a mouth breather? _____ □ Yes □ No

Any apprehension of dental care? _____ □ Yes □ No

Does patient gag or vomit easily? _____ □ Yes □ No

Previous orthodontic consultation? _____ □ Yes □ No

Doctors Name: _____

Previous orthodontic treatment? _____ □ Yes □ No

Doctors Name: _____

Does patient want orthodontic treatment? _____ □ Yes □ No

MEDICAL HISTORY

Physician: _____ City: _____

Last physical exam: _____ Ht: _____ Wt: _____

Is patient in good health? _____ □ Yes □ No

Under a physician's care? _____ □ Yes □ No

History of major illness or surgery? _____ □ Yes □ No

Taking any medication? _____ □ Yes □ No

Name of medication: _____

Taken for: _____

Name of medication: _____

Taken for: _____

DOCTOR'S NOTES

CHECK ANY OF THE FOLLOWING PATIENT HAS OR HAS HAD:

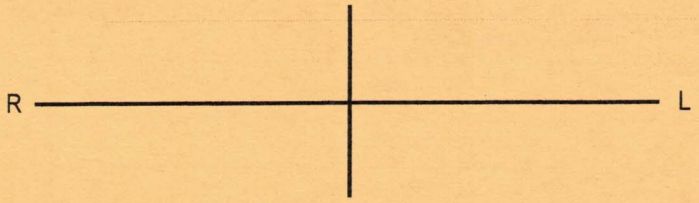
□ Rheumatic heart disease
□ Heart problems
□ High or low blood pressure
□ Stroke
□ Diabetes
□ Anemia
□ Nervous condition
□ Pneumonia
□ Jaundice
□ Liver problem
□ Asthma or hay fever
□ Tuberculosis
□ Ulcer
□ Bleeding problem
□ Epilepsy
□ Seizures
□ Kidney problem
□ Endocrine problem
□ Hepatitis
□ Sinus problems
□ Pain in or near ears
□ Ringing in ears
□ Fainting or dizziness
□ Bone problem
□ Mumps
□ Chicken Pox
□ Venereal disease
□ Measles
□ Frequent colds
□ Arthritis
□ Artificial joints
□ Artificial valves
□ Allergies
□ Reaction to drugs
□ Tonsils removed
□ Adenoids removed
□ Wisdom teeth removed
□ Clicking jaw joint
□ Frequent headaches
□ Periodontal disease

History given by: X _____ Date: _____ Dr. Review _____

SIGNATURE OF PATIENT
CONSENT FOR ORTHODONTIC TREATMENT

Revised: 8/7/13

EXISTING



BAND SIZES

7	6	5	4	4	5	6	7

Chief complaint: _____

M P I _____ II _____ III _____

OB: _____% OJ: _____mm

Crossbites: _____

Midline: MX to facial _____ MD to MX_____

Arch length: MX _____mm / MD _____mm

Lip line: _____ Lip posture: _____

Facial symmetry: _____

Profile: _____

TMJ: R _____ L _____

Max opening (A to A) _____mm

Lateral movement: R: _____mm / L _____mm

Soft tissue exam: _____

Frenum: _____

Tonsils and adenoids: _____

Oral hygiene: _____

Caries visible: _____

Disposition of case: _____

_____

_____

Expected duration: _____

Estimated fee: _____

Extractions needed: _____

_____

Comments:_____

_____

_____

_____

DATE	RECALL VISITS