

Day	Date	Time	Rec	Dr.		

Who called for appt? _____						
Intro Letter	A	B	C	TC	FC	CR

Date _____

PATIENT INFORMATION

Patient Name _____
Last First Middle Sex

Address _____

Home Phone _____ Birthdate _____ S.S.# _____

Is patient a minor? Yes No School _____ Grade _____

(If yes) Parent or Guardian's Name _____

Do you know where we are located? Yes No Directions needed? _____

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

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Residence _____

Mailing Address _____

How long at this address _____ Home phone _____ Work _____

Previous Address (if less than 3 years) _____

S.S.# _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ Yrs. Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ Yrs. Employed _____

S.S.# _____ Birthdate _____ Work Phone _____

ORTHODONTIC INSURANCE

Insured's Name _____ Insured's S.S.# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No

(If Yes) Insured's Name _____ S.S.# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initials) _____

Name patient likes to be called _____ Age _____

Special activities/interests _____

Present at exam Mother Father Guardian Patient only _____ Assistant _____ Doctor _____

Siblings in treatment _____

DENTAL HISTORY

Family Dentist _____

How often do you visit your family dentist for cleanings? _____

Good exp. _____ Bad exp. _____

How often do you brush your teeth? _____

Do your gums bleed? _____ Yes No

Do you have any discomfort in the teeth, face, jaw-joint? _____ Yes No

Are you aware of your jaws making noises? _____ Yes No

Have you had any trauma involving face or teeth? _____ Yes No

Do you require premedication prior to dental treatment? _____ Yes No

Other important dental history information? _____ Yes No

Previous Ortho TX _____

Have parents/siblings had Ortho TX or bite problems? _____ Yes No

ORAL HABITS

Lip biting? _____ Yes No

Difficulty closing lips? _____ Yes No

Mouth breathing? _____ Yes No

Speech problems? _____ Yes No

Swallowing problems? _____ Yes No

Grinding of teeth? _____ Yes No

Thumb/Finger sucking? _____ Yes No

Other _____

CLINICAL EXAMINATION

CHIEF CONCERNS:

D.D.S. (What are his concerns?) _____

Parent (Did you notice it before?) _____

Patient (What would you like to see changed about your teeth?) _____

FINDINGS:

ERUPTION



TMJ-Pain _____ Click/Pop _____ Crepitation _____ Deviation _____

Crowding _____ Missing _____

Overbite _____ Overjet _____ Deep _____ Open _____

Classification _____ R _____ L _____

Facial Symmetry _____

Midlines _____ Max to face _____ Max to mand _____

Other _____

PROBLEM SUMMARY:

Alignment: Crowding _____ Spacing _____ Malalignment _____ Eruption Problem _____

Bite: Class I _____ Class II - Overbite _____ Class III - Underbite _____

Deepbite _____ Openbite _____ Crossbite _____

Other _____

RECOMMENDATIONS:

Records/Consult _____ Observation _____ No TX _____

Discussion: _____

RECORDS REQUIRED:

Full Diagnostic Records _____

Records Fee Quoted _____

Partial/Additional Records _____

Study Models _____ Surgery Doubles _____

Periapicals _____ Full _____ 3+5 _____ 8's _____

LHP _____ Frontal _____ Oblique _____ Wrist _____

Photos - Intraoral _____ Extraoral _____

EXAM OUTCOME

Records Date _____

Consultation Date _____

No TX Indicated _____

Will call back - (Reason) _____

WCB FOLLOW-UP

1. 2-Week Phone Call _____

Outcome: _____

2. Second Phone Call _____

Outcome: _____

3. Letter _____

Outcome: _____