WELCOME!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

PATIENT INFORMATION

Date: _____ 20__

Name _____
First Name Middle Initial Last Name

Address: _____ Home Phone ( ) _____

E-mail: _____ Cell Phone: ( ) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Names and ages of children in your family _____

Patient's Dentist _____ Phone ( ) _____ Physician _____ Phone ( ) _____

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person Responsible for Account _____
First Name Middle Initial Last Name

Relation to Patient _____ Birthdate __ - __ - __ Soc. Sec. # ___ - ___ - ____

Address (if different from patient's) _____

_____ Phone ( ) _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Do you have Orthodontic Insurance Coverage? _____

Insurance Company _____

Group # _____ Policy # _____ Subscriber # _____

MEDICAL HISTORY

Is patient in good health? ..... ☐ Yes ☐ No Does patient have any history of major illness? ..... ☐ Yes ☐ No

Has the patient ever been under the care of a physician for illness? ☐ Yes ☐ No Please list: _____

Check any of the following for which the patient has been treated:

Diabetes ☐ AIDS ☐ Bone Disorders ☐ Nervous Disorders ☐ Pneumonia ☐ Anemia ☐ Tuberculosis ☐ Liver Involvement ☐

Heart Trouble ☐ Epilepsy ☐ Prolonged Bleeding ☐ Endocrine Problems ☐ Rheumatic Fever ☐ Asthma ☐ Kidney Involvement ☐ Fainting or Dizziness ☐

Does patient have tendency to colds? ☐ Yes ☐ No Sore throats? ☐ Yes ☐ No Ear infections? ☐ Yes ☐ No

Have tonsils and adenoids been removed? ☐ Yes ☐ No At what age? _____

List any drugs or medications now being taken. Give reasons: _____

_____

List any allergies or drug sensitivity: _____

PLEASE COMPLETE BOTH SIDES

Name_____ Age _____ Sex _____ Case Number _____

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ..... ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? ..... ☐ Yes ☐ No Until what age? _____

Does the patient have any speech problems? ..... ☐ Yes ☐ No

Is the patient a mouth breather? ☐ Yes ☐ No While awake ☐ Yes ☐ No While asleep ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? ..... ☐ Yes ☐ No

Has an orthodontist been consulted previously? ..... ☐ Yes ☐ No

Reason for consultation _____

X_____

DO NOT WRITE BELOW THIS LINE Signature

Skeletal_____

Dental - Molar Rt _____ Lt _____

Cuspid Rt _____ Lt _____

Overbite _____

Overjet _____

Missing or Impacted Teeth _____

Crossbite _____

Arch Length - Upper _____mm ☐ Crowding ☐ Spacing

Lower _____mm ☐ Crowding ☐ Spacing

Tooth Size Discrepancy _____

Median Line _____

Profile _____

Lip Posture _____

Eruption Pattern _____

Habits _____

Frenum _____

Periodontal _____

T.M.J. - Max. Open _____mm

Lateral Rt _____mm Lt _____mm

Click Rt _____ Lt _____

Pain Rt _____ Lt _____

Excess Mobility - Rt _____ Lt _____

Locking Rt _____ Lt _____

Other _____

Teeth Present:

Right																Left
				E	D	C	B	A	A	B	C	D	E			
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
				E	D	C	B	A	A	B	C	D	E			

Misc. _____

Probable Treatment _____

Est. Tx. Time _____

Est. Fee _____

Who Present: _____

DATE		FEE

DATE		FEE