Lives Change Here

Metal/ Ceramic Braces
Invisalign Teen/Full
TMJ Therapy

Patient Information

COMPLETE BOTH SIDES

Date ____________________

Patient's Name ____________________ (Last / First / Middle)

Address ____________________ (Street / City / State/Zip)

Home Phone __________ Birthdate __________ Social Security # __________

If patient is a minor, give parent's or guardian's name ____________________

E-mail : __________ Cell Phone: __________ Carrier: __________

Hobbies ____________________

School ____________________

Dentist __________ How did you hear of our office? __________

Responsible Party Information

Driver's LIC# __________ Exp. __________

Name ____________________ (Last / First / Middle) __________ Marital Status

Residence ____________________ (Street / City / State/Zip)

Mailing Address ____________________ (Street / City / State/Zip)

Home Phone __________ Cell Phone __________ Work Phone __________

Previous address (if less than 3 years) ____________________ (Street / City / State/Zip)

Social Security # __________ Birthdate __________ Relationship to Patient __________

Employer __________ Address __________ Occupation __________

Spouse's Name __________ Relationship to Patient __________

Employer __________ Address __________ Occupation __________

Social Security # __________ Birthdate __________ Work Phone __________

Dental Insurance Information

Insured's Name __________ Insured's Soc. Sec. # __________

Insurance Company __________ Group No. __________ Local No. __________

Insurance Co. Address ____________________

*Insured's Employer ____________________

Do you have dual coverage? ☐ Yes ☐ No If yes:

Insured's Name __________ Insured's Soc. Sec. # __________

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 ____________________

Please complete the following (check one):

- Is patient in good health? .... ☐ Yes ☐ No
- Is patient subject to nervous disorders, fainting, etc.? Please list ________________________ ☐ Yes ☐ No
- Have you been under the care of a medical doctor during the past two years? .... ☐ Yes ☐ No
- If yes, for what? ____
- Does patient have a history of heart trouble, asthma, kidney or liver involvement, allergy (seasonal or food) or any other systemic disorders? If yes, please list ________________________ ☐ Yes ☐ No
- Is patient taking medication for heart disease, diabetes, other?.. ☐ Yes ☐ No
- If yes, please list drug and dosage ____
- Is patient allergic to any medication, latex or substance? Please list ________________________ ☐ Yes ☐ No
- Has patient tested positive for any of the following?: ☐ Yes ☐ No
- ____Hepatitis A (Infectious) B (serum) ____H.I.V. Positive ____A.I.D.S.
- Does patient bleed easily? .... ☐ Yes ☐ No
- Has patient experienced any unfavorable reaction from any previous dental treatment? .... ☐ Yes ☐ No
- Date of last dental cleaning exam: ____
- Have you used any of these substances?
  ☐ Fosamax ☐ Actonel ☐ Aredia ☐ Zometa (Bisphosphates) ☐ Corticosteroids

WOMEN Are you: _____Pregnant? _____Nursing?

This medical History is accurate and current as of __________ ________________________
DATE SIGNATURE

Medical History Update: 1__________ 2__________ 3__________
Initial & Date Initial & Date Initial & Date

Consent

I consent for x-rays and an oral evaluation by the doctor.
I understand that, where appropriate, credit bureau reports may be obtained.
I consent to be notified of future appointments and office updates by email or text.

Signature (Parent's signature if minor) ____

Dr. Signature ____________________ Date: ____________ Update 1 ____________ Update 2 ____________

FOR OFFICE USE ONLY : DIAGNOSIS

CLASSIFICATION OF MALOCCLUSION: ☐ I ☐ II (Subdivision R ☐ L ☐) ☐ II/1 ☐ II/2 ☐ II, End-on ☐ III

*Abnormal Conditions: ________________________

General Profile:	☐ Straight	☐ Concave	☐ Convex
Maxilla:	☐ Normal	☐ Protrusive	☐ Retrusive
Mandible:	☐ Normal	☐ Prognathic	☐ Retrognathic
Upper Lip:	☐ Balanced	☐ Short	☐ Long
Lower Lip:	☐ Balanced	☐ Curled	☐ Protrusive
Lips:	☐ Relaxed	☐ Tense	☐ Flaccid
Lips at Rest:	☐ Together	☐ Apart	
Nose:	☐ Acceptable	☐ Prominent	☐ Deficient
Chin Button:	☐ Acceptable	☐ Prominent	☐ Deficient
Nasolabial Angle:	☐ Normal	☐ Acute	☐ Obtuse
Lower Face HT	☐ Normal	☐ Reduced	☐ Increased
Gingival Display:	☐ None	☐ Papilla	☐ Excessive
Mentalis:	☐ Normal	☐ Hypoactive	☐ Hyperactive
T.M.J.	☐ No Signs	☐ Pain	☐ Clicking
Trauma:	☐ No	☐ Yes ____________	

Dental Eruption: Normal Early Late Unknown(Adult) Asymmetrical pattern

Tooth size Discrepancies: ☐ Not Apparent ☐ Anterior ☐ Posterior

Upper Anterior Alignment:	☐ Normal	☐ Crowding	☐ Spacing
Lower Anterior Alignment:	☐ Normal	☐ Crowding	☐ Spacing
Overjet:_______mm	☐ Normal	☐ Moderate	☐ Extreme
Overbite:_______%	☐ Normal	☐ Moderate	☐ Deep
	Anterior	Posterior	
Crossbite:	☐ No ☐ Yes	☐ No ☐ Yes	R L ☐ Narrow Post
Open Bite:	☐ No ☐ Yes	☐ No ☐ Yes	R L
Curve of Spee	☐ Normal	☐ Straight	☐ Excessive
Upper Midline	☐ Center	☐ Right____mm	☐ Left ____mm
Lower Midline	☐ Center	☐ Right____mm	☐ Left ____mm
Oral Hygiene:	☐ Good	☐ Fair	☐ Poor
Gingiva:	☐ Healthy	☐ Marginal	☐ Inflamed
	☐ Bleeding	☐ Hypertrophic	☐ Recessed
Attached Gingiva:	☐ Adequate	☐ Marginally Adequate	☐ Problematic
Oral Cancer:	☐ NOS/SX	☐ Positive, Tongue, Gingiva, Cheek	
Habits: ☐ None	☐ Thumb	☐ Tongue Thrust	☐ Other

Abnormal Frenum: Upper ☐ Lower ☐ Lingual ☐ None ☐

DENTITION:
Development Stage:
☐ Primary
☐ Early Mixed
☐ Middle Mixed
☐ Late Mixed
☐ Permanent

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			

Proposed Treatment: Recall ☐ Date 1)______________ 2) ______________
____
____
____ TX Time ________

Fee Quoted ______________ / Insurance ______________ Down ____________ Monthly__________

*Fee is appliable for 6 months from exam date: Sig:______________________ Date:__________