MILES of SMILES™ orthodontics

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 _____ (Initial & Date) 2 _____ (Initial & Date) 3 _____ (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

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				

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 ☐

Proposed Treatment: Recall ☐ Date 1) _____ 2) _____

_____

_____

_____ TX Time _____

Fee Quoted _____ / Insurance _____ Down _____ Monthly _____

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