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):

Question		
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?: ____Hepatitis A (Infectious) B (serum) ____H.I.V. Positive ____A.I.D.S.	☐ Yes	☐ No
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

What is your chief complaint? ______

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

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

			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			

LEFT

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

______

______ TX Time ______

Fee Quoted ______ / Insurance ______ Down ______ Monthly ______

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