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The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

1. About You

Today's Date

Name

☐☐

Name Preferred

Male

Female

Birth Date

Age

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

SS#

Home Ph.

Cell/Other

Work Ph.

Email

Employer

Employer's Address

How long there?

Occupation

When and where are the best times to reach you?

Other family members seen by us

Relationship

Dentist

Last visit date

2. Spouse Information

Name

Employer

Work Ph.

Ext

SS#

Birthdate

3. Person Responsible for Account

Name

Relation

Billing Address

City, State, Zip

Work Ph.

Ext

Home Ph.

Employer

SS#

Date of Birth

4. Primary Dental Insurance

Insurance Co. Name

Insurance Co. Phone No.

Insured's Name

Relationship to Patient

Insured's Birth date

SS#

Insured's Employer

5. Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician: ☐ Yes ☐ No

Please explain _____

Please discuss any serious medical problems that you have had:

Are you allergic to any of the following drugs?

Yes/No

☐ ☐ Penicillin

☐ ☐ Aspirin

☐ ☐ Erythromycin

☐ ☐ Tetracycline

Yes/No

☐ ☐ Dental Anesthetics

☐ ☐ Codeine

☐ ☐ Latex

☐ ☐ Other

List any other drugs that you are allergic to

List any medications you are currently taking

Yes/No

☐ ☐ Heart Attack/Stroke

☐ ☐ Cancer/Chemotherapy

☐ ☐ Heart Murmur

☐ ☐ Rheumatic Fever

☐ ☐ HIV+/AIDS

☐ ☐ Heart Surgery/Pacemaker

☐ ☐ Mitral Valve Prolapse

☐ ☐ Artificial Bones/Joints

☐ ☐ Artificial Valves

☐ ☐ Sinus Problems

Yes/No

☐ ☐ Frequent Headaches

☐ ☐ Epilepsy/Seizure/Fainting

☐ ☐ Diabetes/Tuberculosis (TB)

☐ ☐ Drug/Alcohol Abuse

☐ ☐ Hemophilia/Abnormal Bleeding

☐ ☐ Congenital Heart Defect

☐ ☐ Asthma/Arthritis

☐ ☐ Hepatitis

☐ ☐ Blood Transfusion

8. Dental History

Why have you come to the orthodontist today?

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Yes/No

☐ ☐ Are you currently in pain?

☐ ☐ Have you ever had a serious/difficult problem associated with any previous dental work?

☐ ☐ Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?

☐ ☐ Do you like your smile?

☐ ☐ Do your gums ever bleed?

Who may we thank for referring you to our office?

Signature

Date

Office Use Only

Office Use Only

Office Use Only

	Jaw	RIGHT SIDE		LEFT SIDE	
		Molar	Cuspid	Molar	Cuspid
Class I					
Class II					
Div.I					
Div.II					
Class III					

Oral Hygiene ☐ Excellent ☐ Good ☐ Fair ☐ Poor

TMJ ☐ Normal ☐ Popping/Crepitus L/R ☐ Pain/L/R

Lip/Muscle Posture ☐ Lip Strain ☐ Mentalis Strain

Arch length:

Upper ☐ Excess ☐ Adequate ☐ Deficient _____mm

Lower ☐ Excess ☐ Adequate ☐ Deficient _____mm

Overbite ☐ Deep ☐ Normal ☐ Open _____%

Overjet _____mm

Habits ☐ Tongue thrust ☐ Thumb/finger

☐ Mouthbreathing

Abnormal frenum ☐ Upper ☐ Lower

Probable ☐ Extraction ☐ Non-Extraction ☐ Borderline

Crossbite: R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Midline R _____ L

Deciduous Teeth R E D C B A | A B C D E L
E D C B A A B C D E

Missing

Permanent Teeth R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Notes: _____

Recommendation: ☐ Treat Now _____

☐ Recall: ☐ 3 mo. ☐ 6 mo. ☐ 1 yr.

☐ No treatment

Estimated Tx Time _____ Months _____ Fee

U/L Clarity _____

U/L Invisalign _____

Next Appt: _____

Letters:

☐ Records TBD ☐ Wait for TX ☐ NC ☐ TY Re ☐ FU Pt