

Adult form

Referred By _____ Date _____
 Patient's Name _____ Preferred Name _____
 Birthdate: _____ Age _____ Sex _____ Married _____ Single _____ Other _____
 Dentist _____ Physician _____
 Patient SSN _____ Relationship to Insured _____
 Home Address _____
 City/State/Zip _____
 Home Phone _____ Work Phone _____ Cell _____
 Occupation _____ Employed By _____
 Primary Dental Insurance _____
 Insurance Subscriber _____
 SSN: _____ Date of Birth: _____
 Occupation _____ Employed By _____
 Name of any family members we have seen _____
 Names and ages of other children in the family _____
 Person(s) responsible for payment of account, if applicable _____
 Address and relationship to patient _____

MEDICAL HISTORY

Do you consider yourself in good health? Y / N If not, why? _____
 Do you have any history of major illness? (Please list with dates) _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

| | | | | | | | |
|------------------|--------------------------|-----------------------|--------------------------|--------------------|--------------------------|------------------|--------------------------|
| HEART TROUBLE | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | ATTENTION DEFICIT | <input type="checkbox"/> | LIVER INVOLVMENT | <input type="checkbox"/> |
| MITRAL VALVE PRO | <input type="checkbox"/> | ANEMIA | <input type="checkbox"/> | KIDNEY PROBLEMS | <input type="checkbox"/> | HEPATITIS | <input type="checkbox"/> |
| HEART MURMUR | <input type="checkbox"/> | EPILEPSY | <input type="checkbox"/> | ENDOCRINE PROBLEMS | <input type="checkbox"/> | BLOOD DISORDERS | <input type="checkbox"/> |
| RHEUMATIC FEVER | <input type="checkbox"/> | ASTHMA | <input type="checkbox"/> | PROLONGED BLEEDING | <input type="checkbox"/> | DIABETES | <input type="checkbox"/> |
| PNEUMONIA | <input type="checkbox"/> | FAINTING OR DIZZINESS | <input type="checkbox"/> | TUBERCULOSIS | <input type="checkbox"/> | OTHER _____ | <input type="checkbox"/> |

Do you have a tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores _____
 List any drugs or medications now being taken and reason: _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY: _____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last dental X-rays _____
 Have there been injuries to the face, mouth or teeth? Y / N If yes, describe and give date _____
 Do you have any speech problems? Y / N Have you ever been told you have periodontal disease? Y/N
 Any pain in or near the ears? Y / N
 Have you been informed of any missing or extra permanent teeth? Y / N
 Has an orthodontist been consulted previously? Y / N
 Have you ever had orthodontic treatment before? Y / N If yes when? _____
 Interests or hobbies _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may at the discretion of this office; use the services of one or more credit reporting services.

Signature _____ Reviewed By: _____

OFFICE USE

Date _____

Chief complaint _____

Habits: _____

Trauma _____

TMJ EXAMINATION: Does patient have or report any TMD Symptoms: Y / N

TMD History Required: Y / N

Comments: _____

Extra oral exam

Profile: convex-straight-concave

Midface def: none-mild-moderate-severe

LFH: long-average-short

Chin: weak-avg-strong

Naso-labial angle: acute-avg-obtuse

Mento-Labial sulcus: deep-avg-shallow

Incisor Pro: retrusive-avg-protrusive

Lip incomp: none-mild-moderate-severe

LipVermillion: thin-avg-thick

Frontal: Square-Ovoid-Round-Tapering

Symmetry:

Incisor at rest:

Incisor @ smile:

Gingiva @ smile:

Negative Space: none-mild-mod-severe

SmileToothContour: reverse-flat-avg

Intra oral exam

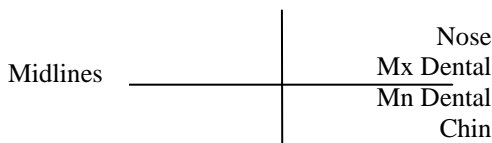
Frenum: high-avg-low

Diastema:

Hygiene: 1 2 3 4 5 (5 best)

Attached Gingiva:

Pathology:



Notes: _____

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |
| | | | 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 |
| | | | E | D | C | B | A | A | B | C | D | E | | | |
| | | | | | | | | | | | | | | | |

- N-ANKYLOSED
- C-CARIES
- X-EXTRACTED
- S-SUPERNUM.
- O-CONG. MISSING
- A-ABNORM SHAPE
- I-IMPACTION
- D-DECID.
- P-CHIPPED
- M-MOBILITY
- W-DECALCIFICATION
- R-ROOT CANAL TX

| | |
|---|-----|
| | PSR |
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |

Crowding/Spacing Maxilla _____ mm Mandible _____ mm CR/CO _____ mm direction _____

Angle class: RM _____ RC _____ LM _____ LC _____ OJ= _____ mm OB= _____ mm Crossbites _____

Comments: _____

RECOMMENDATION

RADIOGRAPHS NEEDED: Pano _____ Lateral Ceph _____ PA Ceph _____ Periapical _____ Other _____

Interceptive Tx _____ Limited Tx _____

Full Tx _____ Habit Tx _____

Consults Needed _____ Extractions _____

Tx time _____ Orthognathic Surgery _____

Fee Range _____ Stage: One Two Three

Disposition: Recall _____ (months) Records _____ Will call _____ No tx _____

_____ N¹V: _____

_____ N²V: _____

_____ N³V: _____

_____ N⁴V: _____

_____ N⁵V: _____