Darron R. Mortenson, DMD, MS

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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 ____
Hm Phone __________________Wk Phone ________________Cell_______________ Email ________________
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	☐	HIV/AIDS	☐	ATTENTION DEFICIT	☐	LIVER INVOLVMENT	☐
MITRAL VALVE PRO	☐	ANEMIA	☐	KIDNEY PROBLEMS	☐	HEPATITIS	☐
HEART MURMUR	☐	EPILEPSY	☐	ENDOCRINE PROBLEMS	☐	BLOOD DISORDERS	☐
RHEUMATIC FEVER	☐	ASTHMA	☐	PROLONGED BLEEDING	☐	DIABETES	☐
PNEUMONIA	☐	FAINTING OR DIZZYNESS	☐	TUBERCULOSIS	☐	OTHER ___________	☐

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:**

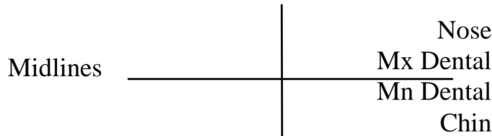
Incisor at rest: **Incisor @ smile**: **Gingiva @ smile**:

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: ______________________

8	7	6	E 5	D 4	C 3	B 2	A 1	A 1	B 2	C 3	D 4	E 5	6	7	8
8	7	6	5 E	4 D	3 C	2 B	1 A	1 A	2 B	3 C	4 D	5 E	6	7	8

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___

______________________ N^1V: ______________

______________________ N^2V: ______________

______________________ N^3V: ______________

______________________ N^4V: ______________

______________________ N^5V: ______________

❍Insurance confirmed with patient ~ ❍Letter to GD ~ ❍Procedure Letter ~ ❍Pre-authorization sent