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Adult form

Referred By _____ Date _____
Patient's Name _____ Preferred Name _____
Birthdate _____ Age _____ Sex _____
Dentist _____ Physician _____
Patient SSN (used to check insurance benefits) _____
Home Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____
Occupation _____ Employed By _____
Primary Dental Insurance _____
Marital Status? Married Single Divorced Separated Widow(er)
Spouse's Name, if applicable _____
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

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
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? _____
List any musical instruments played _____
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 _____

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

Lip Vermillion: thin-avg-thick

Frontal: Square-Ovoid-Round-Tapering

Symmetry:

Incisor at rest:

Incisor @ smile:

Gingiva @ smile:

Negative Space: none-mild-mod-severe

Smile Tooth Contour: reverse-flat-avg

Intra oral exam

Frenum: high-avg-low

Diastema:

Hygiene: 1 2 3 4 5 (5 best)

Attached Gingiva:

Pathology:

Midlines	Nose
	Mx Dental
	Mn Dental
	Chin

Notes: _____

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

_____ N¹V: _____

_____ N²V: _____

_____ N³V: _____

_____ N⁴V: _____

_____ N⁵V: _____