Braces Braces Braces

Referred By_____ Date _____
Name_____ Preferred Name _____
Birthdate _____ Age_____ Sex_____ Current Dentist_____
SSN_____
Home Address_____ Home Phone _____
City/State/Zip _____ Work Phone_____
Occupation _____ Cell Phone_____
Employed By _____
Primary Dental Insurance _____ E-mail: _____
Name of any family members we have seen _____

MEDICAL HISTORY

Are you in good in health?_____ Do you have any history of major illness? _____
Please list (give 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 tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores _____
Have tonsils and adenoids been removed? _____ What Age? _____ 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 X-rays _____
Have youi had a Panoramic/Panorex X-ray? **Y / N / Don't know** If yes, When? _____
Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _____
_____
Any pain in or near the ears? **Y / N** Do you have any speech problems? **Y / N**
Have you been informed of any missing or extra permanent teeth? **Y/ N**
Has an orthodontist been consulted previously? **Y / N**
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 **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:**

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
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: _____

_____'s *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