Associated Orthodontists EST. 1969

FOR ADULTS: WELCOME TO OUR PRACTICE

Date: _____ OPMS#: _____
Doctor: CY D S P
Location: J F M P B
Exam With: _____

PATIENT INFORMATION

PATIENT NAME: _____ SS#: _____ DOB: _____ AGE: _____

PREFERRED NAME: _____ EMAIL: _____ MALE ❑ FEMALE ❑

ADDRESS: _____ PHONE: (____)_____ CELL: (____)_____

CITY: _____ STATE: _____ ZIP: _____ SCHOOL/EMPLOYER: _____

HOBBIES/SPECIAL INTERESTS: _____

NAME OF GENERAL DENTIST: _____ PHONE : (_____)_____

NAME OF OTHER FAMILY MEMBERS TREATED HERE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

SPOUSE'S INFORMATION

NAME: _____

BIRTHDAY: _____ SS#: _____ ADDRESS: _____

EMAIL: _____ PHONE: (____) _____ CELL: (___) _____

EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: (____) _____

PATIENT DENTAL/MEDICAL HISTORY

WHY HAVE YOU COME TO THE ORTHODONTIST TODAY? _____

_____

DO YOU LIKE YOUR SMILE? _____ ❑ YES ❑ NO

ARE YOU CURRENTLY IN PAIN? _____ ❑ YES ❑ NO

YOUR CURRENT DENTAL HEALTH IS: _____ ❑ GOOD ❑ FAIR ❑ POOR

HAVE YOU EVER HAD ANY SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK?

_____ ❑ YES ❑ NO

HAVE YOU EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT? _____ ❑ YES ❑ NO

DO YOUR GUMS EVER BLEED? _____ ❑ YES ❑ NO

HOW MANY TIMES A WEEK DO YOU FLOSS? _____

HOW MANY TIMES A WEEK DO YOU BRUSH? _____

TYPES OF BRISTLES: _____ ❑ HARD ❑ MEDIUM ❑ SOFT

DO YOU HAVE A PERSONAL PHYSICIAN? _____ ❑ YES ❑ NO

NAME: _____ PHONE #: _____

YOUR CURRENT PHYSICAL HEALTH IS: _____ ❑ GOOD ❑ FAIR ❑ POOR

ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR? _____ ❑ YES ❑ NO

EXPLAIN: _____

ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____ ❑ YES ❑ NO

LIST: _____

YES	NO		YES	NO	
❑	❑	HEART MURMUR	❑	❑	CONGENITAL HEART DEFECT
❑	❑	CANCER	❑	❑	CONVULSIONS/EPILEPSY
❑	❑	DIABETES	❑	❑	ABNORMAL BLEEDING
❑	❑	RHEUMATIC FEVER	❑	❑	HEARING IMPAIRMENT
❑	❑	HIV+/AIDS	❑	❑	ANY OPERATIONS
❑	❑	HEMOPHILIA	❑	❑	ANY STAYS IN HOSPITAL
❑	❑	ASTHMA	❑	❑	HANDICAPS/DISABILITIES
❑	❑	HEPATITIS	❑	❑	ALLERGIES TO ANY DRUGS
❑	❑	TUBERCULOSIS	❑	❑	HISTORY OF SCARLET FEVER
❑	❑	HEART ATTACK	❑	❑	ARTIFICIAL VALVES
❑	❑	KIDNEY/LIVER PROBLEMS	❑	❑	HEART SURGERY/PACEMAKER
❑	❑	SHINGLES	❑	❑	MITRAL VALVE PROLAPSE
❑	❑	FEVER BLISTER	❑	❑	ARTIFICIAL BONES/JOINTS
❑	❑	VENEREAL DISEASE	❑	❑	SEVERE/FREQUENT HEADACHES
❑	❑	ULCERS/COLITIS	❑	❑	HI/LOW BLOOD PRESSURE
❑	❑	EMPHYSEMA	❑	❑	DRUG/ALCOHOL ABUSE
❑	❑	SINUS PROBLEMS	❑	❑	BLOOD TRANSFUSION
❑	❑	PROSTHESIS	❑	❑	ANEMIA/RADIATION TX
❑	❑	DIFFICULTY BREATHING	❑	❑	GLAUCOMA

OTHER: _____

FOR WOMEN ONLY

ARE YOU TAKING BIRTH CONTROL PILLS? ❑ YES ❑ NO

ARE YOU PREGNANT? ❑ YES ❑ NO WEEK #: _____

ARE YOU NURSING? ❑ YES ❑ NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN	❑ YES ❑ NO	ERYTHROMYCIN	❑ YES ❑ NO
CODEINE	❑ YES ❑ NO	TETRACYCLINE	❑ YES ❑ NO
LATEX	❑ YES ❑ NO	OTHER:	_____
PENICILIN	❑ YES ❑ NO		_____

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE: _____ DATE: _____

PRIMARY DENTAL INSURANCE

NSURANCE CO. NAME: _____

NSURANCE PHONE: _____

ROUP/POLICY #: _____

NSURED'S NAME: _____

ELATIONSHIP TO PATIENT: _____

NSURED'S DOB: _____

S#/ID#: _____

NSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the reating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protecte ealth information to carry out payment activities in connection with this claim.

SIGNATURE: _____ DATE: _____

hereby authorize and direct payment of the dental benefits otherwise payable to me, irectly to the below named dentist or dental entity.

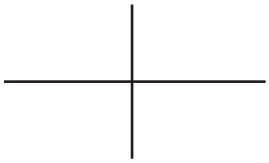
SIGNATURE: _____ DATE: _____

OFFICE USE ONLY

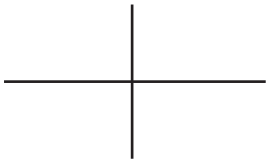
ROFILE	MANDIBLE	SYMMETRY	LIPS AT REST	FACIAL HEIGHT
15 convex	118 mesognathic	000 symmetrical	058 together	121 normal
16 concave	119 retrognathic	039 mandible to RT	059 apart	122 short
17 straight	120 prognatic	039 mandible to LT	060 trapped	123 long

DENTAL LEVEL 000 primary 000 secondary 000 mixed

TEETH PRESENT:



TEETH MISSING:



OLAR CLASS	CROWDING	SPACING	MAX MIDLINE	MAND MIDLINE
01 Class I	007 none upper	005 upper	000 normal	000 normal
02 Class II div 1 RL	008 none lower	019 diastema	040 to RT	042 to RT
03 Class II div 2 RL	015 upper sl mod sev	006 lower	041 to LT	043 to LT
04 Class III	015 lower sl mod sev			

OVERBITE	OVERJET	CROSSBITE	ENAMEL DEFECTS
025 mod 25-75%	036 mod 1-3mm	026 anterior cross	096 decalcification
022 deep 75-100%	037 excess 4-6mm	shape	097 defects
021 100% +	038 severe 7+	028 posterior	098 attrition
024 openbite	039 end-end	029 max buccal	379 abfractions
027 edge-edge			

MJ SYMPTOMS	MANDIBULAR MOVEMENT	PERIO	RANGE OF OPENING
51 none R,L	036 mod 1-3mm	064 healthy	110 normal _____ mm
60 neg/bad test	037 excess 4-6mm	055 gingivitis	111 limited _____ mm
62 click/pop R,L	038 severe 7+	057 recession	
pening, closing, lateral	039 end-end	056 periodontitis	
55 crepitus R,L			
56 condylar pain R,L			
57 muscle pain			

COMMENTS: _____