

# Braces Braces Braces

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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	<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 DIZZYNESS	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>

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 \_\_\_\_\_

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## DENTAL HISTORY

Date of last dental cleaning \_\_\_\_\_ Date of last X-rays \_\_\_\_\_  
Have you 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

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

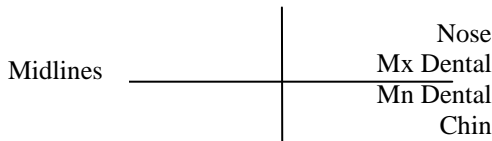
Frenum: high-avg-low

Diastema:

Hygiene: 1 2 3 4 5 (5 best)

Attached Gingiva:

Pathology:



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<sup>1</sup>V: \_\_\_\_\_

N<sup>2</sup>V: \_\_\_\_\_

N<sup>3</sup>V: \_\_\_\_\_

N<sup>4</sup>V: \_\_\_\_\_

N<sup>5</sup>V: \_\_\_\_\_

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