

What brought you to see us? Why are you here? \_\_\_\_\_

Referred By \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Mother's Name \_\_\_\_\_ SSN \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employed By \_\_\_\_\_

Father's Name \_\_\_\_\_ SSN \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employed By \_\_\_\_\_

Parent's Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widow(er) \_\_\_\_\_

Name of any family members we have seen \_\_\_\_\_

Names and Ages of Other Children in the family \_\_\_\_\_

Person(s) responsible for Payment of Account \_\_\_\_\_

Address and Relationship to Patient \_\_\_\_\_

**MEDICAL HISTORY**

Is the patient in good health? \_\_\_\_\_ Does the patient 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"/>

Does patient 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 \_\_\_\_\_

Has the patient reached puberty: Girls-has she started menstruation \_\_\_\_\_ If so date of onset \_\_\_\_\_

Boys-has his voice changed \_\_\_\_\_

**DENTAL HISTORY**

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

Has the patient 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 \_\_\_\_\_

Has the patient ever sucked a thumb or fingers? Y/N Age \_\_\_\_\_

Any pain in or near the ears? Y / N Does the patient 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 Has either parent had orthodontic treatment? Y / N

List any musical instruments played \_\_\_\_\_

Interests or hobbies \_\_\_\_\_

Signature (parent or guardian's) \_\_\_\_\_

OFFICE USE

Date \_\_\_\_\_

Chief complaint \_\_\_\_\_ Profile \_\_\_\_\_

Symmetry \_\_\_\_\_ Lip Posture \_\_\_\_\_ Lip Competence \_\_\_\_\_

U1 exposed rest \_\_\_\_\_ Smile \_\_\_\_\_ Gingiva exposed rest \_\_\_\_\_ Smile \_\_\_\_\_ Nose: L / N / S Chin: L / N / S

Oral tissues \_\_\_\_\_ Pathology \_\_\_\_\_

Hygiene 1 2 3 4 5 (5 best) Frenum \_\_\_\_\_ Diastema \_\_\_\_\_

Gingiva \_\_\_\_\_ Tonsils \_\_\_\_\_

	1	2	3	4	5	6
PSR						



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

- 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

Crowding/Spacing Maxilla \_\_\_\_\_ mm Mandible \_\_\_\_\_ mm CR/CO \_\_\_\_\_ mm direction \_\_\_\_\_

Angle class: RM \_\_\_\_\_ RC \_\_\_\_\_ LM \_\_\_\_\_ LC \_\_\_\_\_ OJ= \_\_\_\_\_ mm OB= \_\_\_\_\_ mm Crossbites \_\_\_\_\_

Open bite \_\_\_\_\_ Habits \_\_\_\_\_ Trauma \_\_\_\_\_

TMJ EXAMINATION Does patient have or report any TMD Symptoms Y / N

Comments \_\_\_\_\_ Protrusive \_\_\_\_\_ mm

Max. Vol. opening \_\_\_\_\_ mm Max. Forced opening \_\_\_\_\_ Lateral: Right: \_\_\_\_\_ mm Left: \_\_\_\_\_ mm

Clicking: Right \_\_\_\_\_ Left \_\_\_\_\_ Comments \_\_\_\_\_

Crepitus: Right \_\_\_\_\_ Left \_\_\_\_\_ Pain: Right \_\_\_\_\_ Left \_\_\_\_\_ Joint / Muscular Deviations \_\_\_\_\_

Headaches \_\_\_\_\_

RADIOGRAPHS NEEDED: Pano \_\_\_\_\_ Lateral Ceph \_\_\_\_\_ PA Ceph \_\_\_\_\_ Periapical \_\_\_\_\_ Other \_\_\_\_\_

RECOMMENDATION

No Tx. \_\_\_\_\_ Recall \_\_\_\_\_ Records \_\_\_\_\_

Early Tx \_\_\_\_\_ Partial Tx \_\_\_\_\_

Full Tx \_\_\_\_\_

Consults: Perio \_\_\_\_\_ Extractions \_\_\_\_\_ Endo \_\_\_\_\_

Estimates: Tx time \_\_\_\_\_ Orthognathic Surgery \_\_\_\_\_

Fee Range \_\_\_\_\_ Letter type \_\_\_\_\_

Disposition: Recall \_\_\_\_\_ Records \_\_\_\_\_ Appt. made \_\_\_\_\_ Will call \_\_\_\_\_

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