NEW PATIENT INFORMATION FORM

PATIENT INFORMATION Date : _____

Last Name: _____First Name _____ Birthday (Day/Mo/Yr): _____

Gender : M F Home No: _____ Cell No:_____ Work No._____

Address: _____City: _____Zip Code: _____

Parent/Guardian Name: _____ Primary Contact email: _____

Describe your orthodontic problem in your own words: _____

Family Dentist:_____ Ph: _____Family Physician: _____Ph:_____

Whom may we thank for referring you to our office? _____

_____

PATIENT EXAMINATION (ORTHODONTIST USE ONLY)

☐CHIEF COMPLAINT: _____

Hygiene: Good/ Fair/ Poor Caries Rate: Low/ Mod/ High Ging.Infl: Min/ Mod/ High Perio. Involvement: Min/ Mod/ High

Teeth Present:_____/_____ Teeth Missing:_____/_____
/ /

Summary_____

Angle Class: Molar Relationship: Right Class_____ mm_____ Left Class_____ mm_____
Canine Relationship: Right Class_____ mm_____ Left Class_____ mm_____

☐ **Summary**: Age___ in Early/Late Mixed /Adult Dentition with Class ___ Div ___ malocclusion _____

☐ OVERJET: _____mm ☐ OVERBITE: _____mm

☐ CROWDING: Upper: No/Mild/Mod/Severe Lower: No/Mild/Mod/Severe ☐ SPACING: Upper ___ Lower ___

Summary:_____

☐ Midline _____/_____ ☐ Crossbites _____/_____ ☐ Dental Anomalies_____/_____
/ / /

☐ Rotations _____/_____ ☐ Impactions_____/_____
/ /

Summary: _____

☐ HABITS: Bruxer / Tongue thrust _____ ☐Frenal Attachments _____

Mandibular Mvmt: Opening_____ Left Lateral_____ Right Lateral_____ Protrusive_____ Deviations_____

Summary: _____

TMJ Exam Joint Sounds: Right_____Left_____ Joint Pain: Right_____ Left _____

Symptoms/History Headaches : Yes / No Neck/Shoulder Pain: Yes / No

Clenching/Grinding of teeth: Yes / No Closed lock: Yes / No

☐ **Summary**: Significant TMJ findings No / Yes _____

☐ PROFILE: Straight / Concave / Convex profile with Normal / Protrusive / Retrusive lip soft tissue

Notes:_____

_____

Recommended Treatment Plan: _____

_____

_____

_____

Patient /Parent Decision _____

_____

TX Cost $ _____