NAME: _____ SEX: _____ DOB: __/__/__ DENTIST: _____ D.D.S. TEL#: (____) ____-____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____ SS#: _____ H-TEL #: (____)____-____ X: ____

EMPLOYER / SCHOOL _____ W-TEL #: (____)____-____ X: ____

CELL #: (____)____-____

EMAIL: _____

WHO REFERRED YOU OR HOW DID YOU CHOOSE OUR OFFICE _____

FATHER/HUSBAND: _____ D.O.B. ___/___/___ S.S. #: ____-____-____

ADDRESS: _____ CITY: _____ ZIP: _____ H-TEL #: (____)____-____

OCCUPATION: _____ W-TEL#: (____)____-____ X: ____

EMPLOYER / SCHOOL _____ CELL#: (____)____-____

E-MAIL: _____

MOTHER/WIFE: _____ D.O.B. ___/___/___ S.S. #: ____-____-____

ADDRESS: _____ CITY: _____ ZIP: _____ H-TEL #: (____)____-____

OCCUPATION: _____ W-TEL#: (____)____-____ X: ____

EMPLOYER / SCHOOL _____ CELL#: (____)____-____

E-MAIL: _____

HEALTH: GOOD: ☐ FAIR: ☐ POOR: ☐

ALLERGIES: 1 ☐ FOOD 2 ☐ DRUG 3 ☐ HAYFEVER 4 ☐ ASTHMA 5 ☐ OTHER

GIVE NO. AND DETAILS: _____

HAS PATIENT HAD ANY OF THE FOLLOWING: (PLEASE CHECK)

1 ☐ HEPATITIS	6 ☐ DIABETES	11 ☐ THYROID PROBLEMS	16 ☐ SINUS PROBLEMS	21 ☐ H.I.V. POS.
2 ☐ FREQUENT HEADACHES	7 ☐ HEART DISEASE	12 ☐ KIDNEY TREATMENT	17 ☐ ARTHRITIS	22 ☐ AIDS
3 ☐ CEREBRAL PALSY	8 ☐ HEMOPHILIA	13 ☐ BLEEDING GUMS	18 ☐ CONVULSIONS OR SEIZURES	
4 ☐ RHEUMATIC FEVER	9 ☐ EPILEPSY	14 ☐ LIVER DISEASE	19 ☐ THROAT INFECTIONS	
5 ☐ FREQUENT COLDS	10 ☐ EXCESSIVE BLEEDING	15 ☐ COLD SORES OR FEVER BLISTERS	20 ☐ DIFFICULTY BREATHING THRU NOSE	

OTHER: _____

NO AND DETAILS FROM ABOVE: _____

PHYSICIAN: _____ UNDER PHYSICIANS CARE AT PRESENT: _____

FOR WHAT: _____

LIST DRUGS TAKEN REGULARLY & REASON: _____

DENTAL: LAST VISIT: ___/___/___ DENTAL WORK BEING DONE NOW: ____ IF YES, WHAT: _____

HAS PATIENT EVER RECEIVED A BLOW TO THE TEETH: YES ____ NO ____ IF YES, EXPLAIN: _____

HAS THE PATIENT HAD PREVIOUS ORTHODONTIC TREATMENT: YES ____ NO ____ IF YES, BY WHOM: _____ WHEN: ____/____/____

CONCERNS: ALIGNMENT OF TEETH: ☐ DENTAL PROTRUSION ☐ FACIAL FEATURES: ☐ IF YES, WHICH: _____

FUNCTIONAL DIFFICULTY: ☐ OTHER (EXPLAIN): _____

WHO FIRST NOTICED THE NEED FOR ORTHODONTIC TREATMENT: _____

FOR OFFICE USE ONLY

PRESENT AT CONSULT 1: _____ CONSULT 2: _____

OTHER FAMILY MEMBERS SEEN	D.O.B.	EXAM DATE : O/C	STAT : DATE	STAT : DATE	STAT : DATE
	/ /	/ / :	: / /	: / /	: / /
	/ /	/ / :	: / /	: / /	: / /
	/ /	/ / :	: / /	: / /	: / /
	/ /	/ / :	: / /	: / /	: / /
	/ /	/ / :	: / /	: / /	: / /

CORRESPONDENCE:

CONSULT LETTER P.TX ___/___/___ CONSULT LETTER F.TX ___/___/___ REF LETTER: ___/___/___ START LETTER: ___/___/___ OTHER REF THANK YOU ___/___/___

CONTRACT: ___/___/___ (RETURNED, SIGNED: ___/___/___) POTENTIAL RISK & LIMITS: ___/___/___ (RETURNED, SIGNED: ___/___/___)

COMMUNICATION LETTER PT ___/___/___ COMMUNICATION LETTER DDS ___/___/___ TIME LIMIT LETTER: ___/___/___ TL DATE (MO/YR): ___/___

DRS EARLY RA LETTER: ___/___/___ RAL FINANCIAL ___/___/___ REQUEST: ___/___/___ (RETURNED, SIGNED: ___/___/___)

RECORDS: #1: OH FILM: ☐ WITH WHOM: _____ ORTHO INFO BOOKLET: ☐ TOOTHBRUSH, PASTE, DISCLOSING TABLETS: ☐

#2: ___/___/___ RA: ___/___/___ FINAL RECORDS: ___/___/___ OTHER: _____ ___/___/___, _____ ___/___/___

APPLIANCE FITTING: ___/___/___

GAVE MODELS: ☐ THERABITE: ☐ FLOURIDE Rx: ☐ OH CARD: ☐ WAX: ☐ BREAKAGE LETTER: ☐ 10 HFT LETTER ___/___/___ RPE LETTER ___/___/___

HEADGEAR CHART: ☐

TALK TO PATIENT/PARENT AT APPLIANCE APPOINTMENT: ☐ FOLLOW UP TELEPHONE CALL (DATE: ___/___/___ TIME: ___:___) (DATE: ___/___/___ TIME: ___:___)

EXT Rx: ☐ (DATE: ___/___/___ PANX GIVEN: ☐ RET'D: ___/___/___ EXT DONE: ☐) PANX GIVEN: ___/___/___ RET'D: ___/___/___

EXT Rx: ☐ (DATE: ___/___/___ PANX GIVEN: ☐ RET'D: ___/___/___ EXT DONE: ☐) PANX GIVEN: ___/___/___ RET'D: ___/___/___

POSITIONER SEATING: DATE: ___/___/___ POS FILM: ☐ POS TALK: ☐ FAMILY PRESENT: _____ POS LETTER: ☐