ORTHODONTIC ACQUAINTANCE CARD

PATIENT'S NAME _____ Date of birth _____ Sex: M ☐ F ☐

Nick Name _____ Age (yr) _____ (mo) _____ Phone # _____

Address _____ City _____ Zip _____

School _____ Grade _____ Interests _____

Names of other children in family _____ Ages ____ / ____ / ____ / ____ / ____

Father's Name _____ Occupation _____

Employed by _____ Business Phone _____

Mother's Name _____ Occupation _____

Employed by _____ Business Phone _____

Parents are: Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Patient's Dentist _____ Patient's Physician _____

Dentist's Address _____ Physician's Address _____

Dentist's Phone _____ Physician's Phone _____

Referred by _____ Date of last dental exam _____

Do you have Orthodontic Insurance? Yes ☐ No ☐ Name of Company _____

Name of Responsible Party _____ Address _____

MEDICAL HISTORY

Is patient in good health? Yes ☐ No ☐

Has the patient ever been under the care of a physician for a major illness? Yes ☐ No ☐

Please list _____

Check any of the following for which you have been treated:

☐ Diabetes	☐ Bone disorders	☐ Kidney problem	☐ Prolonged bleeding
☐ Pneumonia	☐ Anemia	☐ Tuberculosis	☐ Fainting/Dizziness
☐ Heart trouble	☐ Epilepsy	☐ Hepatitis	☐ Nervous disorders
☐ Rheumatic Fever	☐ Asthma	☐ Liver involvement	☐ Other _____

Have tonsils and adenoids been removed? Yes ☐ No ☐ At what age? _____

List any drugs or medications now being taken. Give reason: _____

_____

List any allergies or drug sensitivity: _____

DENTAL HISTORY

Yes ☐ No ☐ Have there been any injuries to the face, mouth, or teeth?

Yes ☐ No ☐ Does the patient have any speech problems?

Yes ☐ No ☐ Has the patient ever sucked a finger or a thumb?

Yes ☐ No ☐ Is the patient a mouth breather?

Yes ☐ No ☐ Have you been told of any missing or extra teeth?

Yes ☐ No ☐ Does the patient have sensitive teeth?

Yes ☐ No ☐ Does the patient grind or clench his teeth?

Yes ☐ No ☐ Does the patient have cracking or clicking in the jaw joint?

Yes ☐ No ☐ Does the patient's jaw ever lock?

Yes ☐ No ☐ Does the patient have headaches? How frequently? _____ Possible cause _____

Yes ☐ No ☐ Does the patient have stiff necks? How frequently? _____ Possible cause _____

Yes ☐ No ☐ Does the patient have ear aches or clogged ears? Possible cause _____ Do antibiotics help? Yes ☐ No ☐

Yes ☐ No ☐ Does the patient's jaw muscles tire quickly while chewing?

Yes ☐ No ☐ Does the patient ever get knots or cramps in his jaw muscles?

Yes ☐ No ☐ Has the patient had any previous orthodontic treatment? Orthodontist's name _____ Location _____

Yes ☐ No ☐ Has the patient consulted an orthondontist before? Orthodontist's name _____ Location _____

Yes ☐ No ☐ Have any of your children had orthodontic treatment? Orthodontist's name _____ Location _____

Yes ☐ No ☐ Has either parent had orthodontic treatment? Orthodontist's name _____ Location _____

Yes ☐ No ☐ Do you have friends that are present or past patients of mine? Names _____

Reason for consultation _____

_____ _____

Parent's Signature Date

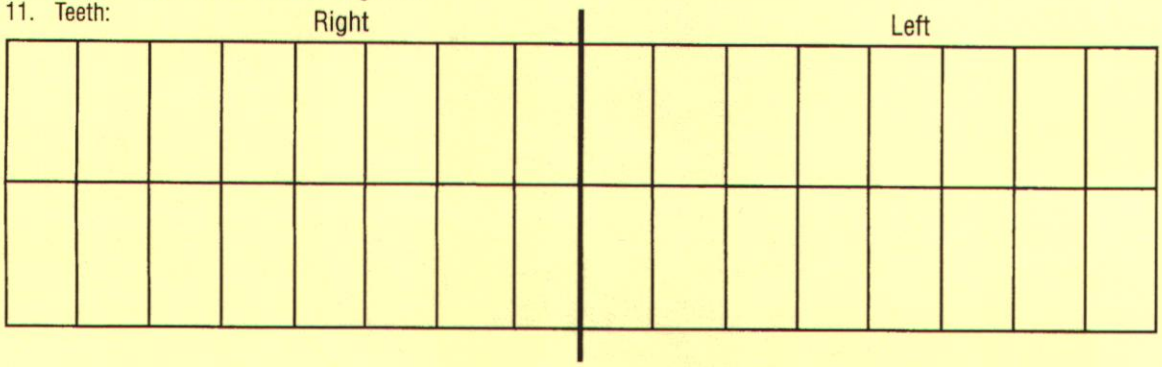
EXAMINATION CHART

EXAM DATE _____

RE EXAM _____

RE EXAM _____

1. Profile: flat convex concave mild mod severe
2. Dentition: normal pro ret max mand bimax
3. Lips: normal parted everted
4. Symmetry: chin R L
5. Habits observed: TT MB LB _____
6. Hygiene: _____ X per day P F G E
7. Soft tissue: normal gingivitis NUG
8. Frenum: normal enlarged max mand
9. Questionable lesions: none _____
10. Caries: low mod severe neglected
11. Teeth:



D-Decalcified
F-fractured
C-caries
S-supernumerary
I-impacted
O-submerged
X-extracted
E-ectopic
M-cong. missing
A-atypical or malformed

12. Eruption time: normal early delayed
13. Prolonged retention of deciduous teeth:
14. Early loss of teeth: decid perm
15. Migrated: to mes dist
16. Class: I II III Div 1 2 mod severe

	R	L
Molar		
Cuspid		

Diagnosis:

17. Overbite: norm deep impinging open _____ mm
18. Overjet: _____ mm
19. Curve of Spee: flat mild mod severe
20. Midline diastema: _____ mm familial frenum
21. TMJ: norm clicks pain limited movement
22. Path of closure: ant post R L
23. Cross bite: unilat R L bilat ant
24. Disharmony of arches: max wide narrow
    mand wide narrow
25. Midline _____ mm
    mm
26. Crowding or rotations:
27. CO = CR
28. Attached Gingivae

RECOMMENDATIONS:

- ☐ Records and consult
- ☐ Recall
- ☐ Extractions
- ☐ Space maintainers
- ☐ No treatment

Fee for Exam _____ R&C _____ Estimated fee _____ Estimated treatment time _____

Other _____

☐ Request x-rays from Dr. _____

Parents will: ☐ follow recommendations ☐ call back

Send letter(s) to source of referral _____ and/or Dr. _____

Date	Service	Time	Next Treatment	Appt