Reading Orthodontics

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Personal History Form

Name First _____ MI _____ Last _____ D.O.B. _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Physician _____ Dentist _____ Referred by _____
Occupation _____ Employed by _____
Business Address _____ Phone _____ EXT ____
Marital Status _____ Spouse's Name _____ No. of Children and Ages _____
Spouse's Occupation _____ Employed by _____
Spouse's Business Address _____ Phone _____ EXT ____
Person Financially Responsible _____ Relationship _____
Dental Insurance: YES NO Orthodontic Coverage: YES NO
Plan Name _____ Subscriber's SS# _____ Group # _____

Medical History

(Please circle yes or no and fill in blanks where required)

1. Date of last medical exam _____ Are you in good health? YES NO
2. Have your tonsils and/or adenoids been removed? At what age? _____ YES NO
3. Any history of major illness? If yes please list _____ YES NO
4. Any allergy or drug sensitivity? If yes please list _____ YES NO
5. Taking any medication now/ If yes please list _____ YES NO
6. Are you under medical and/or psychological care now? Explain _____ YES NO
7. Circle any of the following for which you have or are being treated:

Diabetes	Hepatitis	Pos. HIV Antibody	Heart Trouble	Drug Addiction
Arthritis	Cancer	Nervous Disorders	Brain injury	Blood Transfusion
Asthma	Herpes	Endocrine Problems	Tuberculosis	Rheumatic Fever
AIDS	Epilepsy	Thyroid Problems	Infectious Mono	Prolonged Bleeding
Tonsillitis	ARC	High Blood Pressure	Pregnancy	Low Blood Pressure

8. Do you have, or have you ever had any medical condition not mentioned above? YES NO

Dental History

1. Are you in good dental health? YES NO
2. Date of last dental exam _____ Full mouth X-rays taken? When? _____ YES NO
3. Have you had any injuries to your face, mouth or teeth? Describe _____ YES NO
4. Any oral habits such as lip biting, tongue thrusting or finger sucking? YES NO
5. Have you ever had speech problems or speech therapy? YES NO
6. Are you a mouth breather while asleep or awake? YES NO
7. Are you aware of any missing or extra permanent teeth? YES NO
8. Have you ever had pain, clicking or popping of the jaw joints? Any TMJ Problems? YES NO
9. Do you grind (Brux) your teeth? YES NO
10. Have you ever seen an Orthodontist? If so Dr.'s name _____ Records taken? YES NO
11. Have any members of your family had orthodontic treatment? YES NO
12. Are you overly sensitive to dental pain? YES NO
13. Do you play a wind or reed musical instrument? YES NO
14. What orthodontic problems are you most concerned about? _____
    _____
15. What problem is your dentist most concerned about? _____
    _____

Person filling out this form please sign: Signature: _____ Date: _____

CLINICAL EXAMINATION

EXAM DATE _____
Red
RE-EXAM DATE _____
Blue

1. Profile: flat convex mild/mod/sev concave mild/mod/sev
2. Dentition: normal protruded retruded bimaxillary
3. Lips: normal parted overted full thin cleft repaired
4. Symmetry: chin centered deviates R L occ plane tipped Y N
5. Habits: TT MB LB Other _____
6. Hygiene: _____X per day P F G E fluoride rinse Y N
7. Soft Tissue: norm marg ging'tis NUG edema hyperplastic receded
8. Frenum: Maxillary norm enlarged mandibular norm enlarged
9. Questionable Lesions: None _____
10. Caries Rate: Low Mod High restorations needed _____|_____
11. Teeth:

L - decalcified
F - fractured
R - caries
S - supernumerary
T - impacted
U - submerged
X - extracted
P - ectopic
M - cong. Missing
Y - atypical or malformed

8 1	7 2	6 3	5 4	4 5	3 6	2 7	1 8	1 9	2 10	3 11	4 12	5 13	6 14	7 15	8 16
32 8	31 7	30 6	29 5	28 4	27 3	26 2	25 1	24 1	23 2	22 3	21 4	20 5	19 6	18 7	17 8

12. Eruption time: normal early delayed
13. Prolonged retention of deciduous teeth: _____|_____
14. Early Loss of teeth: _____|_____
15. Migrated: mes ____|____ dist _____|_____
16. Class 1 II div 1 II div 2 sub R L III mod sev

R	L	R	L	R	L

17. Overbite norm deep impinging _____% open ____mm
18. Overjet: _____mm
19. Curve of Spec: flat mild mod severe tilted
20. Midline disastema _____mm max mand familial fornum
21. TMJ: norm click R L pain R L Lim' Mov'mnt Lim' opening
22. Path of closure: deviates to anterior posterior R L
23. Cross bite unilat R L bilat ant _____|_____
24. Diharmony or arches: maxilla norm wide narrow
    mandible norm wide narrow
25. Midline _____|_____
26. Crowding or rotations maxilla mandible _____|_____
27. Swallow: norm teeth apart grimace mentalis activity
28. Other findings:
    Prelim diagnosis:

Recommendations:

_____
_____
_____
_____
_____
_____

Exam Records Est. Fee Ext. Tx Time Date Quoted

Date	Service	Time	Next Treatment	Date