PATIENT INTRODUCTORY INFORMATION

PLEASE PRINT

Patient's SS# ______________________ DATE ______________

Patient's Name: MR. / MRS. / MISS ______________________ LAST ______________________ FIRST ______________________ MIDDLE

Likes to be called (Name) ______________ Age ______ Birthdate ______ MONTH ______ DAY ______ YEAR

Home Address ______ NUMBER ______ STREET ______ CITY ______ STATE ______ ZIP

Home Phone ______ AREA CODE ______ NUMBER ☐ MALE ☐ FEMALE ______ ft. ______ in. HEIGHT ______ lbs. WEIGHT

Name of Parents or Guardian ______________________

Responsible Party's SS# ______________________ Birth Date ______________________

Person Responsible for Account: MR. / MRS. / MISS ______________________

Occupation ______________________ Employed by ______________________

Business Address ______ CITY ______ STATE Business Phone ______ AREA CODE ______ NUMBER

Patient's Dentist ______________________ Address ______ CITY ______ STATE

Patient Referred by ______________________ Address ______ CITY ______ STATE

Patient's Physician ______________________ Address ______ CITY ______ STATE

If you have Dental Insurance, Please Give Us the Following:

Name of Insurer ______________________

Address ______ NUMBER ______ STREET ______ CITY ______ STATE ______ ZIP

Policy Number ______________________ Social Security Number ______________________

GENERAL HEALTH INFORMATION

	YES	NO
Is patient in good health?	______	______
Is patient under a physician's care?	______	______
Is patient taking any drugs or medication?	______	______
Is patient pregnant?	______	______
Has patient had any unfavorable reaction to medical / dental treatment?	______	______
Has patient had tonsils removed?	______	______
Name musical instrument played, if any	______	______
Have any previous family members been examined or treated in our office?	______	______

Check (v) appropriately if patient has or has had any of the following:

- ☐ ALLERGY (FOOD, DRUGS)
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ CLEFT LIP OR PALATE
- ☐ DIABETES
- ☐ DIZZINESS / FAINTING
- ☐ EPILEPSY
- ☐ HIV (AIDS)
- ☐ EXCESSIVE BLEEDING
- ☐ FREQUENT HEADACHES
- ☐ HEART PROBLEMS
- ☐ HEPATITIS
- ☐ HIGH / LOW BLOOD PRESSURE
- ☐ KIDNEY / LIVER PROBLEMS
- ☐ NERVOUS DISORDER
- ☐ JAW POPS OR LOCKS
- ☐ JAW PAIN
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ SPEECH PROBLEMS
- ☐ LIP BITING
- ☐ FINGER OR THUMB SUCKING
- ☐ FINGERNAIL BITING
- ☐ MAJOR OPERATIONS / INJURIES

Signature ______________________

EXAMINATION

Name ____________________

Age ____________________

DEVELOPMENTAL:

SOMATOTYPE
- ☐ NORMO
- ☐ ECTO-
- ☐ MESO-
- ☐ ENDO-

MATURATIONAL
- ☐ PREPUBERAL
- ☐ IN PROGRESS
- ☐ POST-PUBERAL
- ☐ ADULT

SKELETAL
- ☐ ABSENT
- ☐ PRESENT
- ☐ FUSION

EMOTIONAL
- ☐ NORMAL
- ☐ MATURITY
- ☐ PRECOCIOUS

DENTAL
- ☐ NORMAL
- ☐ PERMANENT
- ☐ MIXED

PARENTAL HX.
- ☐ Father malocci. _____ Type
- ☐ Mother malocci. _____ Type

FACIAL:

PROFILE
- ☐ STRAIGHT
- ☐ CONVEX
- ☐ CONCAVE
- ☐ HYPERDIVERGENT
- ☐ HYPODIVERGENT

LIP STR.
- ☐ STRAIGHT
- ☐ CONVEX
- ☐ CONCAVE
- ☐ HYPERTONIC
- ☐ HYPOTONIC

NOSE
- ☐ NORMAL
- ☐ LARGE
- ☐ SMALL
- ☐ IRREGULAR

CHIN
- ☐ NORMAL
- ☐ DEFICIENT
- ☐ EXCESSIVE

DENTAL:

INTRAORAL TISSUES: NORMAL ____________________ HYGIENE ____________________

MISSING SUPERNUMERARY RETAINED

CLASSIFICATION	EXT.	NON-EXT.	CLOSED BITE	OPEN BITE	CROWDING	MUTIL.	SUB-DIV.
☐ CL. I							
☐ CL. II							
☐ Div. 1							
☐ Div. 2							
☐ CL. III							

TREATMENT:

EST. TIME: ______ YEARS ______ MOS. ☐ CONTINUOUS ☐ PHASED

EST. FEE: RANGE ____________________

PAYMENT PLAN ____________________

COMMENTS: ____________________