

# MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE OR THYROID.....	<input type="checkbox"/>	<input type="checkbox"/>
PNEUMONIA.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>	PROLONGED BLEEDING.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY.....	<input type="checkbox"/>	<input type="checkbox"/>	LIVER INVOLVEMENT.....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA.....	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZINESS.....	<input type="checkbox"/>	<input type="checkbox"/>
BONE DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY INVOLVEMENT.....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>

IS THE PATIENT IN GOOD HEALTH? \_\_\_\_\_ YES NO

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASON. \_\_\_\_\_

DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? \_\_\_\_\_

LIST ANY ALLERGIES OR DRUG SENSITIVITY. \_\_\_\_\_

DOES THE PATIENT WEAR CONTACT LENSES? \_\_\_\_\_

HAVE TONSILS AND ADENOIDS BEEN REMOVED? \_\_\_\_\_ WHAT AGE? \_\_\_\_\_

GROWTH IN THE PAST 6 MONTHS \_\_\_\_\_ HAS PATIENT REACHED PUBERTY? \_\_\_\_\_

HEIGHT: PATIENT'S \_\_\_\_\_ MOTHER'S \_\_\_\_\_ FATHER'S \_\_\_\_\_

PATIENT'S PHYSICIAN \_\_\_\_\_ LAST SEEN \_\_\_\_\_

## INSURANCE INFORMATION

INSURED'S NAME \_\_\_\_\_ INSURED'S SOC. SEC.# \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP NO. \_\_\_\_\_ LOCAL NO. \_\_\_\_\_

INSURANCE CO. ADDRESS \_\_\_\_\_ PHONE NO. \_\_\_\_\_

## EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

COMPLETE ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PARENT'S SIGNATURE IF MINOR) \_\_\_\_\_

UPDATES (DATE & INITIAL) \_\_\_\_\_

**CONFIDENTIAL** (for record and pretreatment evaluation)

## EXAMINATION FORM

ANGLE CLASSIFICATION:  
CENTRIC OCCLUSION

	I	II	III	E.E.
RIGHT MOLAR				
RIGHT CANINE				
LEFT MOLAR				
LEFT CANINE				

MAXILLARY ARCH WIDTH CONSTRICTED \_\_\_\_\_ MANDIBULAR ARCH WIDTH CONSTRICTED \_\_\_\_\_

OVERJET \_\_\_\_\_ MM    OVERBITE \_\_\_\_\_ %    PALATALLY IMPINGING    YES \_\_\_\_\_    NO \_\_\_\_\_

MAXILLARY MIDLINE TO MID-SAGITTAL:    ON \_\_\_\_\_    DEVIATED \_\_\_\_\_ MM    R OR L \_\_\_\_\_

MANDIBULAR MIDLINE TO MID-SAGITTAL:    ON \_\_\_\_\_    DEVIATED \_\_\_\_\_ MM    R OR L \_\_\_\_\_

MAXILLARY:    CROWDING \_\_\_\_\_ MM    SPACING \_\_\_\_\_ MM

MANDIBULAR:    CROWDING \_\_\_\_\_ MM    SPACING \_\_\_\_\_ MM

CROSSBITE: R \_\_\_\_\_    L \_\_\_\_\_    ANTERIOR \_\_\_\_\_

MANDIBULAR LATERAL DEVIATION UPON OPENING \_\_\_\_\_ ?    CLOSING \_\_\_\_\_ ?

HABITS:    THUMB \_\_\_\_\_    FINGER \_\_\_\_\_    TONGUE \_\_\_\_\_    LIP \_\_\_\_\_

ABNORMAL FRENUM:    UPPER \_\_\_\_\_    LOWER \_\_\_\_\_    NONE \_\_\_\_\_

ATTACHED GINGIVA:    ADEQUATE \_\_\_\_\_    INADEQUATE \_\_\_\_\_    AREA \_\_\_\_\_

ORAL HYGIENE:    GOOD \_\_\_\_\_    FAIR \_\_\_\_\_    NEEDS IMPROVEMENT \_\_\_\_\_

GINGIVITIS: \_\_\_\_\_    PERIODONTAL DISEASE: \_\_\_\_\_    TISSUE RECESSON \_\_\_\_\_

ENAMEL HYPOPLASIA:    ABSENT \_\_\_\_\_    PRESENT \_\_\_\_\_    TEETH \_\_\_\_\_    MISSING TEETH \_\_\_\_\_

DECALCIFICATION:    ABSENT \_\_\_\_\_    PRESENT \_\_\_\_\_    TEETH \_\_\_\_\_

PROFILE:    CONVEX \_\_\_\_\_    CONCAVE \_\_\_\_\_    STRAIGHT \_\_\_\_\_

TMJ    POP:    R \_\_\_\_\_    L \_\_\_\_\_    NORMAL \_\_\_\_\_

PAIN:    JOINT    R \_\_\_\_\_    L \_\_\_\_\_    MUSCLES    R \_\_\_\_\_    L \_\_\_\_\_    HEADACHES    YES \_\_\_\_\_    NO \_\_\_\_\_

ADDITIONAL FINDINGS: \_\_\_\_\_