Patient Information

Kolin E. Weaver, DDS, MS, Inc.

Patient Information

Date _____ Nickname_____

Patient's Name _____
Last First Middle

Address_____
Street City State Zip

Home Phone _____ Cell _____ Birthdate _____ Sex _____ SSN_____

If patient is a minor, give parent or guardian's name_____ E-mail_____

Whom may we thank for referring you to our office? _____Dentist _____

Names of relative treated here_____ Relationship _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Address _____
Street City State Zip

How long at current address? _____ Home Phone _____ Work Phone _____

Cell Phone_____ E-mail_____

SSN_____ Birthdate _____ Relationship to Patient_____

Employer_____ Occupation _____ No Years Employed _____

Spouse's Name _____
Last First Midldle

Home Phone_____ Cell Phone _____ Work Phone _____

Spouse's Employer _____ Occupation _____ No Years Employed _____

List Additional Financially Responsible Party If Any

Name _____
Last First Middle

SSN _____ Birthdate _____ Relationship to Patient _____

Address _____
Street City State Zip

Employer _____ Occupation _____No Years Employed _____

Dental Insurance Information

Orthodontic Coverage (Office Use) ☐ Yes ☐ No Any Benefit Used (Office Use) ☐Yes ☐ No

Insured's Name _____ Insured's SSN _____DOB_____

Insurance Company _____ Insurance Co Address _____

Insurance Co Phone _____ Group No. _____ Local No._____ ID#_____

Emergency Contact

Name of nearest relative not living with you _____

Address_____ Phone _____

I understand that appropriate credit reports may be obtained, and give permission for photographs to be taken which may be used for educational or promotional materials. Our office respects your privacy and will provide you with our Notice of Privacy Practices upon request.

Signature (Parent's or guardian's signature if minor) _____(OVER)

Medical/Dental History

What are the main concerns you would like the Orthodontist to address? _____

_____

Have you ever been evaluated for orthodontic treatment before?….□ Yes □No
Have there been injuries to your face, mouth, teeth or chin?……□Yes □No
Do you have missing or extra permanent teeth?…….. ……□ Yes □No
Have you ever had pain/tenderness in your jaw joint (TMJ/TMD)? □ Yes □No
Have you experienced problem with previous dental work?…….□ Yes □No
Do you require antibiotics dental treatment?…… □ Yes □ No
Do you have frequent headaches/neck or shoulder pain?……. □ Yes □ No

Do you still have your wisdom teeth?…□Yes □ No
Do you brush your teeth daily?…….. □Yes □ No
Do you floss your teeth daily?……□Yes □ No
Do you still have your tonsils/adenoids □Yes □ No
Is your water fluoridated?…….. □Yes □ No
Are you taking fluoride supplements?… □Yes □No
Do you clench or grind your teeth?…… □Yes □No

(If yes please provide detail) _____

_____

Did/do you have any of the following habits: (Check all that apply)

□ Lip Sucking/Biting □Mouth Breathing □Nail Biting □ Nursing Bottle Habits
□ Speech Problems □ Thumb/Finger Sucking □ Tongue Thrust □Pacifier

Physician's Name _____ Phone _____ Last Visit_____

Does the patient have any history of major illness? □Yes □No If yes, explain. _____

_____

Have you experienced any of the following medical problems: (Check all that apply)

□Abnormal Bleeding □ADD/ADHD □AIDS/HIV+ □Arthritis □Artificial Joints/Valves □ Bleeding Gums
□Cancer □Cerebral Palsy □Chemotherapy □Cold Sores □Convulsions/Seizures □Diabetes
□Difficult Breathing □Epilepsy □Heart Disease □Liver Disease □Dizziness of Fainting □Frequent Colds
□Frequent Headaches □Scarlet Fever □Hemophilia □Hepatitis □Hospital Stays/Surgery □Rheumatic Fever
□Mitral Valve Prolapse □ Thyroid Issues □ Tuberculosis □Prosthetics □Speech Impairment □Hearing Impairment
□Radiation Therapy □Heart Murmur □Sickle Cell Disease/Traits □Asthma
Allergies: □Food □Drug □Latex □Metal/Jewelry □Other_____

List any drugs or medications you are taking. _____

For Office Use Only

Extraoral Exam

Frontal Facial Form: □ Symmetrical Asymmetrical **Midlines**: Pronasale _____ Pogonion_____Maxillary_____Mandibular_____
Lip Relationship: Competent Incompetent **ILG**: _____ **FA Point/Lip:** _____ **Incisal/Exposure:** Rest _____ Smiling _____

Gingival Exposure: Rest_____ Smiling_____ **Vertical Proportions:** Even Uneven **Occlusal Plane:** Parallel/ Canted Up_____

Lateral Facial Form: Straight Convex Concave **Maxillary Position:** WNL Protrusive Retrusive **FALL/DALL**_____mm

Mandibular Position: WNL Protrusive Retrusive **Forehead Shape:** Straight Round Angled **G/T** _____mm **G/S**_____mm

Intraoral Exam

Soft Tissue: Healthy Pathologic **Attached Gingiva:** Adequate Inadequate **Frenal Attachments:** WNL Excessive

Tonsils: Retained Removed **Oral Hygiene**: Good Fair Poor **Caries:** None Evident Present Exam Required

TMJ: Symptomatic Asymptomatic _____

Opening/Excursions: WNL Deficient _____ **Molar Classification:** Right I II III Left: I II III

Overjet: Normal Moderate Excessive Negative Amount____mm **Overbite:** Normal Moderate Deep Open _____mm

Crossbite: None Anterior Posterior Right Left Bilateral

Recommendations:

_____ Recall _____ Full Records _____ Recall _____ Full Records **Estimated Tx Cost $_____**
_____ Recall _____ Full Records _____ Recall _____ Full Records **Estimated Tx Time _____**
_____ Recall _____ Full Records _____ Recall _____ Full Records