PATIENT INFORMATION FORM

carillon FAMILY DENTAL

PATIENT INFORMATION

Name: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ SS#: _____ Occupation: _____

Employer: _____ # of Years Employed: _____

Work #: _____ Home #: _____ Cell #: _____

E-Mail Address: _____

Hobbies/Sports: _____

School: _____ City of School: _____

Other family members seen by us (provide age): _____

Sibling(s) not listed above (current or treated elsewhere): _____

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

Dentist's Name: _____ City: _____ Phone #: _____ Last Visit: _____

Responsible Party's Signature: _____ Today's Date: _____

INSURANCE

INSURANCE: If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance AS A COURTESY for any future treatment, insurance information must be **filled out completely BEFORE** you come in for your Initial appointment (Note: Orthodontics is Dental and TMJ is Medical)

Do you have Orthodontic Insurance? ___ No ___ Yes Carrier: _____ Member ID#: _____

Carrier Address: _____ Carrier Ph#: _____

Name of Primary Insured: _____ Primary Birthdate: _____ Primary SS#: _____

Do you have Secondary Insurance? ____ No ___ Yes Carrier: _____ Member ID#: _____

Carrier Address: _____ Carrier Ph#: _____

Name of Secondary Insured: _____ Secondary Birthdate: _____ Secondary SS#: _____

RESPONSIBLE PARTY

NOTE: If separated/divorced the responsible party of the child is the custodial parent. The person responsible for account and signing contract is the **only person** legally able to acquire Information regarding patient. If responsible party has legal custody of a person under 18 and the relationship to the person is not mother/father, please provide information below.

Name: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ #of Years Employed: _____

Home#: _____ Cell#: _____ SS#: _____ Birthdate: _____

Billing Address: _____

Previous Address (if less than 3 years): _____

Mother's Information: ■ Step Mother ■ Guardian Name: _____ Birthdate: _____

SS#: _____ Home #: _____ Cell #: _____

Father's Information: ■ Step Father ■ Guardian Name: _____ Birthdate: _____

SS#: _____ Home #: _____ Cell #: _____

Who is Responsible for Making Appointments? Name: _____

Relationship to Patient: _____ Home #: _____ Cell #: _____

If you are **NOT** the **Patient** or the **Responsible Party** filling out this form, please provide:

Name: _____ Relationship to Patient: _____

Address: _____ Home #: _____ Cell #: _____

Responsible Party's Signature: _____ Today's Date: _____

EMERGENCY

Primary Physician's Name: _____ Phone#: _____

Physician's Address: _____ City: _____

Name of nearest relative NOT living with you: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

carillon FAMILY DENTAL

DATE: _____

NAME: _____

I. SUBJECTIVE COMPLAINTS AND CONCERNS

A. What are the patient's or parent's main concerns regarding the jaw and teeth?

	Mild	Moderate	Severe
1. Facial Pain	■	■	■
2. Gum Disease/ Recession	■	■	■
3. Gum Problems	■	■	■
4. Headaches	■	■	■
5. Jaw Dysfunction	■	■	■
6. Jaw Joint Sounds	■	■	■
7. Jaw Pain	■	■	■
8. Neck Pain	■	■	■
9. Ringing or "Stuffy" Ears	■	■	■

- ■ Bad Bite
- ■ "Buck" Teeth/ Overjet
- ■ Crowding of Upper Teeth
- ■ Crowding of Lower Teeth
- ■ Crowding of Upper and Lower Teeth
- ■ Crossbite
- ■ Dentist Recommended Seeing an Orthodontist
- ■ Grinding Teeth
- ■ Gummy Smile
- ■ Impacted Tooth/ Teeth
- ■ Improper Tooth Position
- ■ Irregular Shaped Tooth/ Teeth
- ■ Missing Tooth /Teeth
- ■ Mouth Too Small
- ■ Open Bite
- ■ Prominent Low Jaw (too "strong")
- ■ Protrusion of Teeth
- ■ Recessive Lower Jaw (too "weak")
- ■ Rotations
- ■ Small Teeth
- ■ Spaces
- ■ Thumb/ Finger Habit
- ■ Underbite
- ■ OTHER _____

B. Family members with similar problems:

- ■ Father
- ■ Mother
- ■ Brother
- ■ Sister
- ■ OTHER _____

II. MEDICAL DENTAL HISTORY

A. Present Health

	Good	Fair	Poor
1. Physical	■	■	■
2. Emotional	■	■	■
3. Under Stress	■	■	■

B. Has the patient reached puberty? ■ Yes ■ No

C. Has the patient ever had any of the following conditions?

- ■ Allergies
- ■ AIDS / ARC / HIV (Circle)
- ■ Arteriosclerosis
- ■ Asthma
- ■ Autoimmune Disorder
- ■ Blood Disease
- ■ Bone Disorder
- ■ Cancer
- ■ Diabetes
- ■ Dizziness
- ■ Emotional Problems
- ■ Endocrine Problems
- ■ Epilepsy
- ■ Female Problems
- ■ Frequent Headaches
- ■ Glaucoma
- ■ Hay Fever
- ■ Hearing Disorders
- ■ Heart Disease / Surgery
- ■ Hepatitis
- ■ Herpes / Fever Blisters
- ■ High Blood Pressure / Low Blood Pressure (Circle)
- ■ Hospitalized for Any Reason
- ■ Kidney Disease
- ■ Lupus
- ■ Mitral Valve Prolapse
- ■ Pacemaker
- ■ Psychiatric Problems
- ■ Radiation Treatment
- ■ Rheumatic Fever
- ■ Ringing of Ears
- ■ Seizures
- ■ Sinus Problems
- ■ Sleep Disturbance
- ■ Stroke
- ■ Thyroid Problems
- ■ Trauma (to face, teeth, jaws or head)
- ■ Tuberculosis
- ■ Ulcers
- ■ Venereal Disease
- ■ _____

D. **Medications** (Current medications taken by patient):

- Antibiotics
- Birth Control Pills
- Diet Pills (Diuretics)
- Heart Pills (Digitalis, etc.)
- Insulin
- Muscle Relaxants (Valium, etc.)
- Pain Pills (Demerol, Codeine, etc.)
- Sleeping Pills
- Tranquilizers (Elavil, Valium, etc.)
- Vitamins
- OTHER _____

E. **Allergies to Medications/Food** (The patient demonstrates an allergic response to):

- Antibiotics (specifically) _____
- Aspirin
- Codeine
- Dairy Products
- Dental Anesthetics
- Erythromycin
- Food Dyes
- Jewelry / Metals
- Latex
- Pain Pills (specifically) _____
- Wheat
- OTHER _____

F. **Other Pertinent Information** (Has the patient ever had a history of the following?):

1. Other Habits
2. Colds
3. Difficulty Chewing
4. Difficulty Swallowing
5. Finger Sucking
6. Grinding Teeth
7. Headaches
8. Lip Biting
9. Mouth Breathing
10. Pain in Jaw Joint
11. Smoking
12. Snoring
13. Sore Teeth
14. Sore Throats
15. Speech Problems
16. Thumb Sucking
17. Tongue Thrusting
18. Tonsillitis
19. OTHER _____

III. PATIENT'S OR PARENT'S ATTITUDE TOWARD TEETH CARE AND ORTHODONTIC TREATMENT

A. **Regular dental checkups:**

- Twice a year
- Once a year
- Only if necessary
- Never

B. **Patient's interest in orthodontic treatment:**

- Eager for treatment
- Willing if necessary
- Dreading but agrees
- Unwilling

C. **Orthodontic consultation was prompted by:**

- Patient (Name) _____
- Dentist (Name) _____
- Spouse
- Mother / Father / Brother / Sister (Circle)
- Other relative (Name) _____
- Friend (Name) _____
- OTHER _____

D. **Has the patient ever had any unusual dental experience?**

- No _____
- Yes If yes, please explain: _____

_____

E. **Are there any medical, dental, surgical or psychological problems not covered above?**

- No _____
- Yes If yes, please explain: _____

_____

F. **Has the patient ever had a previous orthodontic consultation/treatment?**

- No _____
- Yes If yes, please explain: _____

_____

G. **Health Professional(s)** (Current or have seen previously)

Doctor Name: _____
Reason(s) for treatment: _____
Doctor Name: _____
Reason(s) for treatment: _____
Doctor Name: _____
Reason(s) for treatment: _____

H. **Why are you seeking this consultation?**

- To improve dental appearance
- To improve facial appearance
- To improve general appearance
- To improve longevity of teeth
- To improve self-esteem
- To reduce facial pain
- To reduce headaches/neck aches
- OTHER _____

Comments:

_____

_____

_____

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

_____

Patient/Responsible Party's Signature Date

_____

Orthodontist/General Dentist's Signature Date

Date	Comments

PROFILE
115 convex
116 concave
117 straight

DENTAL LEVEL
000 primary
000 mixed
000 permanent

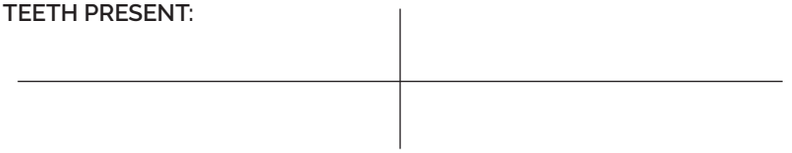
MOLAR CLASS
001 Class I
002 Class II div 1 RL
003 Class II div 2 RL
004 Class III

OVERBITE
025 mod 25-75%
022 deep 75-100%
021 100% +
024 openbite
027 edge-edge

TMJ SYMPTOMS
051 none R, L
380 negload test
052 click/pop R, L
opening, closing, lateral
055 crepitus R, L
056 condylar pain R, L
057 muscle pain

MANDIBLE
118 mesognathic
119 retrognathic
120 prognathic

TEETH PRESENT:



CROWDING
007 none upper
008 none lower
015 upper sl mod sev
016 lower sl mod sev

OVERJET
036 mod 1-3 mm
037 excess 4-6 mm
038 severe 7+
039 end-end

SYMMETRY
000 symmetrical
039 mandibles to RT
039 mandibles to LT
other _____

SPACING
005 upper
019 diastema
005 lower

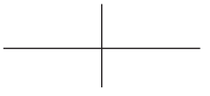
CROSSBITE
025 anterior
028 posterior
029 max buccal

MANDIBULAR MOVEMENT
051 no deviation
053 opening deviation R, L
054 closing deviation R, L

RANGE OF OPENING
110 normal ____ mm
111 limited ____ mm

LIPS AT REST
058 together
059 apart
060 trapped

MAX MIDLINE
000 normal
040 to RT
041 to LT



FACIAL HEIGHT
121 normal
122 short
123 long

TEETH MISSING:

SUPERNUM:

MAND MIDLINE
000 normal
042 to RT
043 to LT

ENAMEL DEFECTS
096 decalcifications
097 defects
098 attrition
379 abfraction

PERIO
084 healthy
085 gingivitis
087 recession
086 periodontitis

COMMENTS: _____