NEW PATIENT INFORMATION

Name________________________________ Date_______________

Birth date________________ Age_________ Home phone______________

Nickname, or prefer to be called_______________________ Cell phone_______________

Home Address____
Street or Box No. City State Zip

Occupation__________________________________ Email______________________________

Business Phone________________________ Social Security #______________________

Business Address____
Street or Box No. City State Zip

Spouse's Full Name__________________________ Occupation_____________________

Business Phone________________________ Social Security #______________________

Business Address____
Street or Box No. City State Zip

Insurance Co._____________Subscriber_______________Policy #_______________________

Insurance Co. Address____________________________________ Phone______________

Family Dentist______________________________ City_____________________

Whom may we thank for referring you?____

Have you previously seen another orthodontist?__________

Orthodontist's Name_________________________ City____________________

List any previous orthodontic treatments____

Has anyone else in your family been treated in our office?________________________________

Has the patient been a thumb-sucker?_________ Is the patient a mouth-breather?___________

List your primary orthodontic concerns____

Chief Complaint____

Hygiene_________________________ TM exam:

Habits__________________________

Heredity_________________________

Profile__________________________

Class_______ Overbite__________ Overjet___________ Competence__________

Midline____________________ Crossbites___________________________________

Retained deciduous teeth, missing permanent teeth:

7 6 E D C B A A B C D E 6 7

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7 6 E D C B A A B C D E 6 7

Mandibular arch____

Maxillary arch____

Caries or deficient restoration____

Health Summary____

FMX_____________ Request from Dr.____

Diagnostic Records____

Proposed treatment____ Fee___________

Comments____

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Recall____________ Service____

Recall Appointment Record

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