DANVILLE ORTHODONTICS

# MEDICAL HISTORY

TODAY'S DATE

PATIENT'S NAME & GENDER M / F | NICKNAME... | BIRTH DATE

HOME ADDRESS (STREET, CITY, STATE, ZIP CODE) | WHO MAY WE THANK FOR SENDING YOU HERE?

HOME PHONE # | OTHER PHONE #...TYPE: _____ | E-MAIL FOR APPOINTMENT REMINDERS

CURRENT DENTIST | CURRENT PHYSICIAN | HOBBIES / INTERESTS

## ALLERGIES (i.e.: medications, latex, dyes, foods, etc.)

## CURRENT MEDICATIONS

## SUSCRIBER INFORMATION (INSURED)...*PRIMARY INSURANCE*

NAME | RELATION

SOCIAL SECURITY # OR MEMBER ID # | BIRTH DATE

INSURANCE CARRIER | PHONE

INSURANCE ADDRESS (P.O. BOX, CITY, STATE, ZIP CODE)

EMPLOYER / OCCUPATION | GROUP/PLAN #

## SECONDARY INSURANCE INFO. / 2nd RESPONSIBLE PARTY

NAME | RELATION

SOCIAL SECURITY # OR MEMBER ID # | BIRTH DATE

INSURANCE CARRIER | PHONE

INSURANCE ADDRESS (P.O. BOX, CITY, STATE, ZIP CODE)

EMPLOYER / OCCUPATION | GROUP/PLAN #

*I am interested in the following forms of treatment:*

☐ Braces ☐ metal ☐ ceramic
☐ Invisalign
☐ Other:

## MEDICAL / DENTAL HISTORY

| Y | N | *PLEASE MARK YES OR NO* |
|---|---|---|
| ☐ | ☐ | AIDS/HIV |
| ☐ | ☐ | ASTHMA |
| ☐ | ☐ | IN GOOD HEALTH |
| ☐ | ☐ | ANEMIA |
| ☐ | ☐ | BONE DISORDERS |
| ☐ | ☐ | TUBERCULOSIS |
| ☐ | ☐ | CURRENTLY PREGNANT |
| ☐ | ☐ | FEVER |
| ☐ | ☐ | DIABETES |
| ☐ | ☐ | PROLONGED BLEEDING |
| ☐ | ☐ | SORE THROAT |
| ☐ | ☐ | ENDOCRINE DISORDER |
| ☐ | ☐ | EPILEPSY |
| ☐ | ☐ | FAINTING OR DIZZINESS |
| ☐ | ☐ | TONSILS REMOVED |
| ☐ | ☐ | ADENOIDS REMOVED |
| ☐ | ☐ | FREQUENT/RECURRING COLDS |
| ☐ | ☐ | LIVER DISORDER |
| ☐ | ☐ | FACE/MOUTH/TEETH INJURY |
| ☐ | ☐ | HEART PROBLEMS |
| ☐ | ☐ | HEPATITIS...TYPE ____ |
| ☐ | ☐ | KIDNEY DISEASE |
| ☐ | ☐ | EAR INFECTION |
| ☐ | ☐ | RHEUMATIC FEVER |
| ☐ | ☐ | HIGH / LOW BLOOD PRESSURE |
| ☐ | ☐ | NERVOUS DISORDER |
| ☐ | ☐ | EMOTIONAL CONCERNS |

| Y | N | *PLEASE MARK YES OR NO* |
|---|---|---|
| ☐ | ☐ | PNEUMONIA |
| ☐ | ☐ | SMOKE/USE TOBACCO |
| ☐ | ☐ | TEETH GRINDING: DAY / NIGHT? |
| ☐ | ☐ | SUCK THUMB...STILL? Y/N |
| ☐ | ☐ | SPEECH PROBLEM |
| ☐ | ☐ | PRIMARILY MOUTH BREATHE |
| ☐ | ☐ | MISSING/EXTRA PERMANENT TEETH |

PLEASE NOTE: _____

☐ ☐ PRIOR ORTHODONTIC CONSULT
☐ ☐ PREVIOUS ORTHO DONE?
IF YES, DONE BY:_____
DATE OF LAST EXAM / CLEANING:
_____

☐ ☐ HAVE YOU EVER BEEN PRESCRIBED ANTIBIOTICS FOR DENTAL TREATMENT.
IF YES, TYPE:_____

☐ ☐ HAVE YOU TAKEN THE DIET MEDICATION Redux, aka. Fen-Phen?

☐ ☐ HAVE YOU TAKEN ANY OSTEOPOROSIS MEDICATIONS, i.e. Fosamas, Aredia, Boniva?

☐ ☐ HISTORY OF ANY OTHER MAJOR ILLNESS? IF YES, DESCRIBE BELOW:
_____
_____
_____

☐ ☐ UNDER PHYSICIAN'S CARE FOR THE ILLNESS ABOVE?

## ASSIGNMENT AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to this patient's health, and it is my responsibility to inform this office of any changes in this patient's medical status. I certify that this patient has insurance coverage with the company/companies listed above and I assign all insurance benefits, if any, directly to Dr. Hoss Abar, DDS, MSD. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

**RESPONSIBLE PARTY'S SIGNATURE / DATE:** _____ / _____-_____-_____

**DOCTOR'S SIGNATURE / DATE:** _____ / _____-_____-_____

DANVILLE ORTHODONTICS

# FINDINGS (...to be completed by the orthodontist)

**Patient's Name:** _____ **Age:** _____ **Sex:** _____ **Today's Date:** _____

**1. Angle Classification and Relation of Segments**

| | RIGHT SIDE | | LEFT SIDE | |
|---|---|---|---|---|
| | Molar | Cuspid | Molar | Cuspid |
| Class I | | | | |
| Class II | | | | |
| Div. II | | | | |
| Class III | | | | |

**2. Dentition:** _____

**Eruption Pattern:** Early ☐ Normal ☐ Late ☐

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | E | D | C | B | A | A | B | C | D | E | | | |
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| | | | E | D | C | B | A | A | B | C | D | E | | | |

**3.** Arch Length - Maxillary - Excess ☐ Adequate ☐ Deficient ☐ Amount: _____mm
Mandibular - Excess ☐ Adequate ☐ Deficient ☐ Amount: _____mm

**4.** Crossbite - Right ☐ Left ☐ Max. Buccal ☐ Max. Lingual ☐

**5.** Overbite - Normal ☐ Open ☐ Closed ☐ _____%

**6.** Overjet - Crossbite ☐ Edge to Edge ☐ Normal ☐ Excessive ☐ Amt. _____%

**7.** Curve of Spee - Deep ☐ Normal ☐ Flat ☐ Reversed ☐

**8.** Median Line - Maxillary Midline to Mid - Sagital _____|_____
Mandibular Midline Rest _____|_____ Occlusion _____|_____

**9.** Path of Closure - Unrestrictive ☐ Restrictive ☐ Contract and Mesially ☐
Psaudo Class III ☐ Contact and Distally ☐

**10.** TMJ - Clicks ☐ Pain ☐ Restrictive Movement ☐ Asymptomatic ☐

**11.** Lip Posture - Together Relaxed ☐ Together Strained ☐ Apart ☐

**12.** Lip Muscle Tone - Hypo ☐ Normal ☐ Hyper ☐

**13.** Abnormal Frenum - None ☐ Labial Upper ☐ Labial Lower ☐ Lingual ☐

**14.** Tonsils and Adnoids - None ☐ Normal ☐ Large and a Problem ☐

**16.** Profile - Restrusive ☐ Flat ☐ Protrusive ☐ Double Protrusive ☐ Satisfactory ☐

**17.** Habits - Tongue Thrust ☐ Frontal ☐ Lateral ☐ Lip Biting ☐
Finger or Thumbsucking ☐ Mouth Breathing ☐ Fingernail Biting ☐
Leaning on Chin or face ☐ Other _____

**18.** Oral Hygiene - Excellent ☐ Fair ☐ Poor ☐ _____

**21.** Consultation Date: _____

**22.** Cavity Clearnce from DDS: Faxed: _____ Received: _____

**23.** Treatment Estimate: _____ Months of Tx:_____

**24.** Estimated Insurance:_____ Down Payment:_____ $ / months:_____

**25.** ☐ Phase 1 ☐ Phase 2 ☐ Ltd. Treatment ☐ Full Treatment ☐ Braces...Type:_____ ☐ Invisalign ☐ Other:_____

**26.** Oral Cancer Screening Notes: _____

**27.** Periodontal Screening Notes: _____

| | |
|---|---|
| **C** | Caries |
| **X** | Extracted |
| **S** | Supernumerary |
| **O** | Congenitally missing |
| **△** | Atypical Form |
| **I** | Impaction |
| **D** | Decalcification |

**OTHER NOTES:** _____

_____

_____ **Doctor's Signature:** _____