ABAR ORTHODONTICS

MEDICAL HISTORY

TODAY'S DATE

PATIENT'S FULL NAME	M/F	NICKNAME….	BIRTH DATE

HOME ADDRESS (STREET, CITY, STATE, ZIP CODE)

WHO MAY WE THANK FOR SENDING YOU HERE?

HOME PHONE #

OTHER PHONE CELL/WORK

E-MAIL FOR APPOINTMENT REMINDERS

CURRENT DENTIST

CURRENT PHYSICIAN

HOBBIES / INTERESTS

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

CURRENT MEDICATIONS

RESPONSIBLE PARTY INFORMATION/ 1st 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 #

2nd RESPONSIBLE PARTY/ 2nd INSURANCE INFORMATION if ar

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	Y	N	PLEASE MARK YES OR NO
☐	☐	AIDS/HIV	☐	☐	PNEUMONIA
☐	☐	ASTHMA	☐	☐	SMOKE/USE TOBACCO
☐	☐	IN GOOD HEALTH	☐	☐	TEETH GRINDING: DAY / NIGHT?
☐	☐	ANEMIA	☐	☐	SUCK THUMB…STILL? Y/N
☐	☐	BONE DISORDERS	☐	☐	SPEECH PROBLEM
☐	☐	TUBERCULOSIS	☐	☐	PRIMARILY MOUTH BREATHE
☐	☐	CURRENTLY PREGNANT	☐	☐	MISSING/EXTRA PERMANENT TEETH
☐	☐	FEVER	PLEASE NOTE: _____		
☐	☐	DIABETES	☐	☐	PRIOR ORTHODONTIC CONSULT
☐	☐	PROLONGED BLEEDING	☐	☐	PREVIOUS ORTHO DONE?
☐	☐	SORE THROAT	IF YES, DONE BY:_____		
☐	☐	ENDOCRINE DISORDER	DATE OF LAST EXAM / CLEANING:		
☐	☐	EPILEPSY	_____		
☐	☐	FAINTING OR DIZZINESS	☐	☐	HAVE YOU EVER BEEN PRESCRIBED
☐	☐	TONSILS REMOVED	ANTIBIOTICS FOR DENTAL TREATMENT.		
☐	☐	ADENOIDS REMOVED	IF YES, TYPE:_____		
☐	☐	FREQUENT/RECURRING COLD	☐	☐	HAVE YOU TAKEN THE DIET MEDICATION
☐	☐	LIVER DISORDER	Redux, aka. Fen-Phen?		
☐	☐	FACE/MOUTH/TEETH INJURY	☐	☐	HAVE YOU TAKEN ANY OSTEOPOROSIS
☐	☐	HEART PROBLEMS	MEDICATIONS, i.e. Fosamas, Aredia,		
☐	☐	HEPATITIS…TYPE ____	Boniva and or Bisphosphonate		
☐	☐	KIDNEY DISEASE	☐	☐	HISTORY OF ANY OTHER MAJOR
☐	☐	EAR INFECTION	ILLNESS? IF YES, DESCRIBE BELOW:		
☐	☐	RHEUMATIC FEVER	_____		
☐	☐	HIGH / LOW BLOOD PRESSURE	_____		
☐	☐	NERVOUS DISORDER	☐	☐	UNDER PHYSICIAN'S CARE FOR THE
☐	☐	EMOTIONAL CONCERNS	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: _____ / ____-____-____

ABAR 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 ☐

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

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: _____