Patient Information

Date:_____

Patient's Name:_____
Last First Middle

Address:_____
Street City State Zip

Home Phone:_____ Birthdate:_____

General Dentist:_____ School:_____ Grade:_____

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

Responsible Party Information

Name:_____
Last First Middle Marital Status

Residence:_____
Street City State Zip

Mailing Address:_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address(if less than 3 yrs.)_____
Street City State Zip

Social Security #:_____ Birthdate:_____ Relationship to Patient_____

Employer_____ Occupation_____ No.Years Employed_____

Spouse's Name_____ Work #_____
Last First Middle

Social Security #:_____ Birthdate:_____ Relationship to Patient_____

Employer_____ Occupation_____ No.Years Employed_____

Insurance Information

Insured's Name:_____ Insured's Soc. Sec. #_____

Insurance Company:_____ Group No._____ Phone#:_____

Insurance Co. Address:_____

Insured's Employer:_____ Do you have dual coverage? Yes ☐ No☐

If yes:

Insured's Name:_____ Insured's Soc. Sec. #_____

Insurance Co._____ Group No._____ Phone #:_____

Insurance Co. Address:_____

Insured's Employer:_____

I hereby authorize Insurance payments made directly to

Signature:_____

Coombs & Beglin Orthodontics
John A. Coombs, DDS, LTD.
Frank Beglin, DDS, MS, LTD.

Emergency Information

Name of nearest relative not living with you:_____

Complete Address:_____

Phone #:_____

I understand that where appropriate, credit bureau reports may be obtained

I certify that the information I have provided is correct

Signature (Parent's signature if minor) _____

Updates (date&initial) _____ _____ _____

Patient's Name _____ Nickname _____ Age _____ Today's Date _____

Birthdate _____ Grade _____ School _____

Who sent you to us _____ Names of brothers and sisters _____

Previous orthodontic consultations or treatment ☐ Yes ☐ No

Plays musical instrument ☐ Yes ☐ No

Previous speech therapy ☐ Yes ☐ No

Type of musical instrument _____

Hobbies _____

MEDICAL HISTORY

YES NO

☐ ☐ Is patient presently under physician's care?
For _____

☐ ☐ Is patient taking any pills, medications, or drugs? _____

☐ ☐ Has patient ever had an unusual reaction to medication? _____

☐ ☐ Is patient allergic to anything? _____

☐ ☐ Has patient had any major surgery? For _____

☐ ☐ Does patient have a chronic problem with ☐ kidney, ☐ heart, ☐ lung, ☐ liver.

☐ ☐ Are there any other medical problems not mentioned above? _____
Describe: _____

☐ ☐ Has patient been diagnosed or treated for any of the following:

☐ Diabetes	☐ Arthritis	☐ Rheumatic fever	☐ Emotional
☐ Epilepsy	☐ Anemia	☐ Heart trouble	☐ Endocrine
☐ Asthma	☐ Fainting	☐ Cerebral palsy	☐ Bone
☐ Tonsils removed	☐ Adenoids removed	☐ Prolonged bleeding	

DENTAL HISTORY

YES NO

☐ ☐ Does patient now suck thumb or fingers?

☐ ☐ Does patient breathe predominantly through the mouth?

☐ ☐ Does the patient clench or grind teeth? ☐ at night ☐ during day

☐ ☐ Does the patient have pain or clicking upon closing the mouth?

☐ ☐ Has the patient had any severe head or face injuries?
When _____

☐ ☐ Have any teeth been injured or chipped due to accidents?
When _____

☐ ☐ Any noticeable difficulty in chewing or swallowing food?

☐ ☐ Has patient been informed of any extra or missing teeth?

☐ ☐ Have any teeth (baby or permanent) been removed by extraction?
Why _____

☐ ☐ Has a dentist ever placed a retainer or space maintainer? _____

☐ ☐ Has any member of the family had orthodontic treatment?
Who _____

☐ ☐ Have you had any previous orthodontic consultation or treatment?

☐ ☐ Would patient mind wearing ☐ bands? ☐ headgear?

☐ ☐ Has patient ever been teased about appearance of his/her teeth?

☐ ☐ Is patient concerned about appearance of his/her teeth?

☐ ☐ Does the patient want his/her teeth straightened?

Month of last dental appointment _____

FOR OFFICE USE ONLY

COMPLAINT:

Patient _____

Parent _____

Dentist _____

FOR OFFICE USE ONLY

1. Angle classification and relation of segments. 2. Dentition

	RIGHT SIDE		LEFT SIDE	
	Molar	Cuspid	Molar	Cuspid
Class I				
Class II				
Div II				
Class III				

RIGHT																		LEFT
	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 - Max — ☐ Excess, ☐ Adequate, ☐ Deficient, Amt. ___ MM
Arch length - Man — ☐ Excess, ☐ Adequate, ☐ Deficient, Amt. ___ MM

4. 3 2 1 | 1 2 3 ☐ Crowded, ☐ Even, ☐ Spaced, Amt. ___ MM
3 2 1 | 1 2 3 ☐ Crowded, ☐ Even, ☐ Spaced, Amt. ___ MM

5. Crossbite ☐ Right, ☐ Left, ☐ Max. Buccal, ☐ Max. Lingual

6. Overbite ☐ Normal, ☐ Open bite, ☐ Close bite ____ %

7. Overjet ☐ Crossbite, ☐ Edge to edge, ☐ Normal, ☐ Excessive, Amt. ___ MM

8. Curve of spee ☐ Normal, ☐ Flat, ☐ Reversed, ☐ Deep

9. Median line — maxillary midline to mid-sagital ____|____
mandibular midline rest ____|____ occlusion ____|____

0. Path of closure ☐ Unrestrictive, ☐ Restrictive, ☐ Contact and mesially
☐ Pseudo class III, ☐ Contact and distally

1. Lip posture ☐ Together relaxed, ☐ Together strained, ☐ Apart

2. Lip muscle tone ☐ Hypo, ☐ Normal, ☐ Hyper

3. Abnormal frenum ☐ None, ☐ Upper, ☐ Lower

4. Tonsils and adenoids ☐ None, ☐ Normal, ☐ Large and a problem

5. Eruption pattern ☐ Early, ☐ Normal, ☐ Late

6. Profile ☐ Retrusive, ☐ Flat, ☐ Protrusive, ☐ Double protrusive, ☐ Satisfactory

7. Habits ☐ Tongue thrust, ☐ Frontal, ☐ Lateral, ☐ Lip biting
☐ Finger or thumb sucking, ☐ Mouth breathing
☐ Fingernail biting, ☐ Leaning on chin or face
☐ Other _____

8. Oral Hygiene ☐ Excellent, ☐ Fair, ☐ Poor

9. Perio cond. ☐ Recession, ☐ Pockets, _____
☐ Attached Ging. _____

10. ☐ TMJ:

	R	L		R	L		R	L
Tight Muscle	☐	☐	Pain	☐	☐	Lateral slide	☐	☐
Click/Pop	☐	☐	Opening	☐	☐	AP slide ____ MM		
Crepitus	☐	☐	History of locking	☐	☐	Initial contact ____|____		

DISCUSSED WITH PATIENT OR PARENT:

PROBLEM:

☐ Class II	☐ Facial imbalance	☐ TMJ Symptoms
☐ Class III	☐ Crowding/spacing	☐ Impaction/missing
☐ Vertical problem	☐ Thumb/tongue	
☐ Over jet	☐ Mandibular shift	

POSSIBLE TREATMENT:

☐ Full bands	☐ Extract ____|____ or ____|____
☐ Partial bands	☐ Serial extraction
☐ Removable	☐ Two phases
☐ Headgear	☐ Surgery _____

Est. treatment time _____ Est. fee _____

Special considerations _____

DISPOSITION:

_____ Models	_____ Photos
_____ Survey	_____ Office consultation
_____ Pano	_____ Phone consultation
_____ Lat.	_____ Recall