Dunn Orthodontics

Welcome

New Patient Registration

(For Patients Age 18 and Under)

Today's Date _____

Patient Name _____ Prefers to be called _____

Address _____

City, State, Zip _____

Home Phone _____ Birthdate _____ Age _____ Sex M F

Who may we contact in case of emergency? _____ Phone _____

Family Dentist _____ Family Physician _____

In your opinion what is your orthodontic problem? _____

_____

Who may we thank for recommending you to our office? _____

Father's Name _____ Birthdate _____ Phone _____

Occupation _____ Employed by _____

Mother's Name _____ Birthdate _____ Phone _____

Occupation _____ Employed by _____

Father's Work # _____ Mother's Work # _____

Brothers and Sisters:

Name _____ Birthdate _____ Name _____ Birthdate _____

Name _____ Birthdate _____ Name _____ Birthdate _____

Person responsible for account _____

If divorce is involved, who is the Custodial Parent? _____

May patient information be released to the noncustodial parent? ❍ No ❍ Yes

Address _____

City, State, Zip _____

Do you have orthodontic insurance coverage? ❍ No ❍ Yes, company _____

Group Number _____ Phone/Contact _____

Social Security # _____

Smiles Worth Celebrating

Clinical Examination _____

Profile:	❍ Convex	❍ Straight	❍ Concave	
Nasolabial angle:	❍ Acute	❍ Normal	❍ Obtuse	
Mentolabial sulcus:	❍ Normal	❍ Deep		

Classification:

Skeletal_____	Dental_____	Cuspid_____	Molar_____	
Overjet_____	❍ Minimum	❍ Normal	❍ Excessive	❍ Neg.
Overbite_____	❍ Open	❍ Minimum	❍ Normal	❍ Deep

Alignment:

MX	❍ Normal	❍ Crowding	❍ Spacing	_____mm
MD	❍ Normal	❍ Crowding	❍ Spacing	_____mm

Transverse:

MX Midline:	_____mm	❍ right	❍ left
MD Midline:	_____mm	❍ right	❍ left
X-bite:	_____		
MX Width:	_____	MD Width:	_____

Diastema: _____ Impactions: _____

Missing Teeth: _____ Habits: _____

Oral Hygiene _____ Enamel Wear: _____

Advice given to parents/patient: _____

_____

Length of tx: _____ Tx Fee: _____

Possible treatment: _____

_____

_____

Comments: _____

_____

_____

_____

Right									Left
a	b	c	d	e	f	g	h	i	j
t	s	r	q	p	o	n	m	l	k

Right															Left
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Health Questionnaire _____

Today's Date

Patient Name | Birthdate

Family Dentist | Date of last visit

Have you ever had the following dental treatment?

- ❍ Orthodontics, date _____, by Dr. _____
- ❍ Periodontal treatment (gum treatment)
- ❍ Mouthguard or splint therapy for jaw joint problems
- ❍ Jaw surgery to change your bite or to correct jaw joint

Do you have or have you had any of the following oral conditions?

- ❍ Sensitive teeth
- ❍ Clenching or grinding
- ❍ Bad breath
- ❍ Pain in the jaw, face
- ❍ Dry mouth
- ❍ Poorly functioning teeth
- ❍ Bleeding gums
- ❍ Pain around ear
- ❍ Mouth breathing
- ❍ Oral habits (thumb sucking, etc)
- ❍ Pain when opening mouth
- ❍ Discolored teeth
- ❍ Food wedging between teeth
- ❍ Swelling or lumps in the mouth
- ❍ Tobacco use
- ❍ Jaw joint sounds or pain
- ❍ Inability to floss between teeth
- ❍ Jaw gets stuck open or closed

Do you have or have you had any of the following medical conditions?

Yes	No		Yes	No		Yes	No	
❍	❍	Rheumatic fever	❍	❍	Congenital heart lesions/murmur	❍	❍	Heart condition
❍	❍	Diabetes	❍	❍	Anemia	❍	❍	Arthritis, swollen joints
❍	❍	Inflammatory rheumatism	❍	❍	Kidney problems	❍	❍	Tuberculosis
❍	❍	Asthma	❍	❍	Yellow jaundice	❍	❍	Hepatitis type _____
❍	❍	Liver disease	❍	❍	High blood pressure	❍	❍	Low blood pressure
❍	❍	Severe headaches	❍	❍	Dizziness or fainting	❍	❍	Convulsions or seizure
❍	❍	Eye problems	❍	❍	Ear problems	❍	❍	Sinus problems
❍	❍	Nose bleeds	❍	❍	Speech problems	❍	❍	Swallowing problems
❍	❍	Easy bruising	❍	❍	Venereal disease	❍	❍	HIV positive
❍	❍	ADD/ADHD						

Are you currently under a physician's care? If yes, describe _____ yes no

Has patient ever been hospitalized or had any serious illness? If yes, describe _____ yes no

Does the patient have any drug allergies? If yes, list medications _____ yes no

Is the patient allergic to latex, metal or vinyl? _____ yes no

Is the patient taking any medication? If yes, list medications _____ yes no

Female patients – could patient possibly be pregnant at the present time? _____ yes no

Has patient ever taken any diet medication (Phen-Fen)? _____ yes no

Patient (or parent) signature _____ Date _____

Dr. Dunn's Signature: _____

Notes: _____

_____

_____