Cosmopolitan ORTHODONTICS

Adult Orthodontic Record

PATIENT INFORMATION

Last Name _____ First Name _____
Nickname or Preferred Name _____ Birth Date ____ / ____ / _____ Sex M [_] F [_]
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Has any family member received treatment at our office? Yes [_] No [_] if yes, who? _____
Dentist _____ Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Last Name _____ First Name _____ Birth Date ____ / ____ / _____ Marital Status _____
Address _____ City _____ State _____ Zip _____
Time at this address _____ Relationship to patient _____ Email _____
Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Current Employer _____ Occupation _____
Spouse's Name _____ Birth Date ____ / ____ / _____ Relationship to patient _____
Current Employer _____ Occupation _____
Work Phone (_____) _____ - _____ May we call you/spouse at work? Yes [_] No [_] Email _____

ORTHODONTIC INSURANCE INFORMATION

Insurance Company (Primary) _____
Address _____
Phone Number (_____) _____ - _____
Group Number _____
Policy Holder Name _____
Policy Holder Soc. Sec. No. ____ - ____ - _____
Policy Holder Birth Date ____ / ____ / _____
Policy Holder Employer _____

Insurance Company (Secondary) _____
Address _____
Phone Number (_____) _____ - _____
Group Number _____
Policy Holder Name _____
Policy Holder Soc. Sec. No. ____ - ____ - _____
Policy Holder Birth Date ____ / ____ / _____
Policy Holder Employer _____

INITIAL EXAM INFORMATION

What is your chief concern in seeking orthodontic care? _____
What is your dentist's main concern regarding the patient's bite? _____
In an effort to avoid records duplication: has another orthodontist been consulted previously? Yes [_] No [_]

Our policy is that the adult who requests treatment is responsible for all fees for services rendered. When appropriate, credit information will be obtained.

Signature _____ **Date** ____ / ____ / _____

SIGNATURE ON FILE

By signing below:

- I authorize the use of this form and its information for all my insurance submissions.
- I authorize this office and its employees to act as my agent in helping me obtain insurance reimbursement.
- I authorize insurance payment directly to this office.
- I authorize the use of a copy of this form which can be used in place of the original.
- I understand where appropriate a credit report may be obtained.

Signature _____ **Date** ____ / ____ / _____

MEDICAL HISTORY

Name of physician _____ Physician's Phone (_____) _____ - _____

please check yes or no for each condition (if yes, please explain)

Allergies
Yes [_] No [_] Acrylic
Yes [_] No [_] Aspirin
Yes [_] No [_] Ibuprofen
Yes [_] No [_] Latex
Yes [_] No [_] Metals
Yes [_] No [_] Nickel
Yes [_] No [_] Vinyl
Yes [_] No [_] Other _____

Yes [_] No [_] Arthritis (Rheumatism)
Yes [_] No [_] Asthma
Yes [_] No [_] Attention Deficit Disorder

Blood disorders
Yes [_] No [_] Anemia
Yes [_] No [_] Bruise easily
Yes [_] No [_] Excessive bleeding
Yes [_] No [_] Other _____

Blood pressure conditions
Yes [_] No [_] high
Yes [_] No [_] low

Yes [_] No [_] AIDS or HIV positive

Yes [_] No [_] Cancer
Yes [_] No [_] Chemo
Yes [_] No [_] Radiation

Cardiovascular conditions
Yes [_] No [_] Angina
Yes [_] No [_] Heart attack
Yes [_] No [_] Heart defect
Yes [_] No [_] Heart murmur
Yes [_] No [_] Stroke
Yes [_] No [_] Other _____

Neurological disorders
Yes [_] No [_] Epilepsy
Yes [_] No [_] Fainting
Yes [_] No [_] Seizures
Yes [_] No [_] Other _____

Yes [_] No [_] Eating disorder
Yes [_] No [_] Headaches/migraines
Yes [_] No [_] Hepatitis
Yes [_] No [_] Immune system disorder
Yes [_] No [_] Kidney disorders

Yes [_] No [_] Oral ulcers
Yes [_] No [_] Respiratory problems
Yes [_] No [_] Rheumatic fever

Sensory conditions
Yes [_] No [_] Hearing
Yes [_] No [_] Tasting
Yes [_] No [_] Vision
Yes [_] No [_] Other _____

Yes [_] No [_] Speech condition (if yes, explain)
_____

Yes [_] No [_] Tonsils/adenoids
Yes [_] No [_] Tuberculosis

Yes [_] No [_] Does your child have any other medical conditions that we should know about?

If yes, please explain _____
_____
_____
_____
_____

MEDICATION HISTORY

Yes [_] No [_] Do you take any prescription medication,over the counter medication, nutritional supplements, or herbal medication?

Please list all medications...

Medication	Taken for

DENTAL HISTORY

Yes [_] No [_] Do you have missing teeth?
Yes [_] No [_] Do you have extra teeth?
Yes [_] No [_] Do you have slowly erupting teeth?
Yes [_] No [_] Do you have unerupted teeth?
Yes [_] No [_] Do you have thin gum tissue?
Yes [_] No [_] Do you brush and floss regularly?

Yes [_] No [_] Are you in good dental health?
Yes [_] No [_] Are your x-rays and fluoride treatments up to date?
Yes [_] No [_] Have you seen the dentist in the past six months?
Yes [_] No [_] Have you experienced any unusual dental problems?
Yes [_] No [_] Is there anything else about your child's dental history that we should know about?

If yes to any above, please explain _____

_____

_____

_____

Now or in the past have you had...

Yes [_] No [_] ...any history of injured teeth?
Yes [_] No [_] ...injury to the head, neck, or jaws?
Yes [_] No [_] ...tooth sensitivity to hot or cold?
Yes [_] No [_] ...history of dental problems?
Yes [_] No [_] ...periodontal or "gum tissue" problems?
Yes [_] No [_] ...bleeding gums when brushing?
Yes [_] No [_] ...food impaction between teeth?
Yes [_] No [_] ...frequent canker sores or cold sores?

Jaw joint history

Yes [_] No [_] ...history of jaw joint pain?
Yes [_] No [_] ...history of jaw joint clicking or locking?
Yes [_] No [_] ...history of facial muscle pain
Yes [_] No [_] ...difficulty chewing, opening, or closing?
Yes [_] No [_] ...history of treatment for TMD or TMJ?

Functional/habit history

Yes [_] No [_] ...history of thumb or finger habit?
Yes [_] No [_] ...history of tongue thrusting?
Yes [_] No [_] ...history of abnormal swallowing?
Yes [_] No [_] ...difficulty eating?
Yes [_] No [_] ...history of mouthbreathing?
Yes [_] No [_] ...history of snoring?
Yes [_] No [_] ...history of tooth grinding?
Yes [_] No [_] ...history of jaw clenching?
Yes [_] No [_] ...history of speech difficulty?
Yes [_] No [_] ...any history of speech therapy?

If yes to any above, please explain _____

_____

_____

_____

Successful orthodontic treatment and beautiful smiles are achieved with a combination of appropriate diagnosis, excellent communication, and personalized attention. In an effort to specifically address your orthodontic concerns, please indicate what you would like orthodontics to accomplish for you:

[_] Enhance aesthetics and appearance
[_] Create facial balance
[_] Improve function, comfort, and stability
[_] Increase self confidence
[_] Enhance overall dental health
[_] Avoid further problems

I have read and understand the previous questions and I certify that the information I have provided is complete and accurate. In addition I acknowledge that I am solely responsible for any errors or omissions that may have been made in the completion of this four page form. As the responsible party I will immediately inform this office in the event of any change in medical and/or dental health status and will acknowledge change in status by signing and dating below.

Signature _____ **On behalf of** _____ **Date** ____ / ____ / _____
(responsible party) (patient)

MEDICAL / DENTAL HISTORY UPDATE

Date	Medical/dental status change?	Signature	Change in status
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		
	Yes [_] No [_]		

FOR OFFICE USE ONLY

Deciduous teeth present

R E D C B A | A B C D E L
R E D C B A | A B C D E L

Permanent teeth present

R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Crossbites

R ——— | ——— L

Molar and Canine classification

	Right side		Left side	
	Molar	Canine	Molar	Canine
Class I				
End to End II				
Class II				
Class III				

Skeletal

	R	L	
Class I	[_]	[_]	
Class II	[_]	[_]	
Class III	[_]	[_]	
Upper midline	[_]	[_]	_____ mm
Lower midline	[_]	[_]	_____ mm

	Mild	Moderate	Severe
Upper Crowding	[_]	[_]	[_]
Lower Crowding	[_]	[_]	[_]

Overbite _____ %
Frenum Inv. [_] Not Inv. [_]
Midline Diastema _____ mm
Overjet _____ mm

Date	Recommendation