

Welcome to our office! We treat people, not just teeth when creating smiles.
Thank you for taking time to complete this form.

Curtis L. Hayden, D.D.S., P. A.

QuickTime™ and a decompressor are needed to see this picture.

Date _____

Patient Information

Patient's Name _____ M / F Birthdate _____ Age _____

Address _____
Street City State Zip Code

School _____ Grade _____ Major _____

Hobbies / Sports _____ Musical Instruments _____

Referred by _____ Other family members or friends treated here? _____

Patient's e-mail address _____ Responsible party's e-mail address _____

Person Responsible for Account _____ Relationship _____

Mailing Address (if different) _____

Home phone _____ Cell phone _____ SSN _____

Occupation / Employer _____ Work phone _____

Parent's or Spouse's Name _____ Occupation / Employer _____

Do you have dental insurance with orthodontic benefits? Y / N Name of Insurance Company _____

Name of Policy Holder _____ DOB _____ ID # _____

Group name _____ Group Number _____ Phone _____

Do you have secondary insurance? Y / N Name of Policy Holder and Company _____

Medical History Patient in good health? Y / N Family Physician _____ Date Last Physical _____

Currently under the care of a physician? Y / N If so, please explain _____

Taking any medications now? Y / N Please list all medications and purpose _____

Please circle Y or N for any illnesses or conditions you have ever had:

Abnormal bleeding	Y/N	Congenital Heart Defect	Y/N	Heart Problems	Y/N	HIV / AIDS	Y/N	Epilepsy	Y/N
Anemia	Y/N	Diabetes	Y/N	Heart Murmur	Y/N	Kidney Problems	Y/N	Rheumatic Fever	Y/N
Arthritis	Y/N	Dizziness / Fainting	Y/N	Hepatitis/Liver Problem	Y/N	Nervous Disorders	Y/N	Tuberculosis	Y/N
Asthma / Allergies	Y/N	Radiation/Chemotherapy	Y/N	Herpes	Y/N	Pneumonia	Y/N	Tumor or Cancer	Y/N
Bone Disorders	Y/N	Gastrointestinal Disorder	Y/N	High Blood Pressure	Y/N	Prolonged Bleeding	Y/N	Eating Disorder	Y/N

Osteoporosis? Y / N Are you taking any form of BISPONATES? Fosamax (alendronate) Actonel (risedronate) Boniva (ibandronate)

Do you **smoke** or **use tobacco** products? Y / N _____ Any problems following tooth extraction or surgery? Y / N

Any unusual reactions or allergies to anesthetics or antibiotics such as penicillin? _____

Ladies, are you expecting? Y / N _____ months Due Date _____ Girls, have you had your first period (menses)? Y / N

Are there any other medical conditions we should be aware of? _____

Assignment & Release: I give the orthodontist permission to release health information to third party payors, and/or consult with other health practitioners as necessary. I consent to the use and disclosure of my protected health information to carry out payment activities in connection with all claims and authorize the use of this signature on all insurance submissions. I understand that when appropriate, credit bureau reports may be obtained. I understand, that as a courtesy my insurance will be filed by this office, but I am financially responsible for all charges whether or not paid by insurance. I understand that my diagnostic records may be used for educational and promotional purposes. My signature below signifies that I understand the above and hereby authorize release of information to third parties for insurance purposes.

Signature _____ **Date** _____
Parent/Guardian or Patient (over 18)

Updates: Initials & Date _____ Initials & Date _____ Initials & Date _____

****Any changes in your health status should be reported at the earliest possible time****

In case of emergency, please call: _____ Phone _____

Chief Concern:

Patient's Name:

Age:

Dental History

Family Dentist: _____

Date of Last Dental Exam/Visit: _____

Has patient had orthodontic treatment before now? Y / N _____

Does the patient have any habits which might have caused the teeth to move? Y / N (i.e., thumb / finger / clothing sucking; finger nail / lip biting)

Has there been any noise, clicking, popping, and/or pain in the jaw joints when moving the lower jaw? Y / N Right / Left / Both

Does the patient have headaches of any kind? Y / N How often? _____

Does the patient grind their teeth at night? Y / N Does the patient clench their teeth together during the day? Y / N

Does the patient have any speech problems? Y / N Has the patient ever had speech therapy? Y / N _____

Does the patient have tonsils & adenoids? Y / N Does the patient snore or have a habit of mouth breathing? Y / N

Any injuries to the teeth? (chipped, bumped, etc.) Y / N _____

Any gum boils or root canal treatment? Y / N _____

Does the patient have bleeding gums? Y / N Canker sores / ulcers in the mouth? Y / N Fever blisters on lips? Y / N

Is there anything else that you feel we should know regarding this patient? _____

Do you require any antibiotics before receiving dental treatment? Y / N (e.g. artificial heart valve, history of endocarditis, heart transplant, congenital heart condition) (Not recommended for MVP, rheumatic heart disease, bicuspid valve disease, calcified aortic stenosis, or congenital heart conditions such as ventricular or atrial septal defects, and hypertrophic cardiomyopathy)

Orthodontist's Review of History: _____

Doctor's Signature _____ Date _____

Consultation / Clinical Findings

Dental Classification I II-1 II-2 III Subdivision R / L

Retained Primary Teeth e d c b a I a b c d e Wear Facets _____ Impacted _____
e d c b a I a b c d e Cross Bites _____ Missing _____

Vertical Overbite _____ Deep Bite _____ Open Bite _____ Transverse _____mm

Horizontal Overjet _____ COS _____ Arch Length _____ / _____ Midlines _____ / _____

CO = CR Mandibular Shift = Forward _____ Right _____ Left _____ 1st contact = _____ Asymmetry _____

Appearance of Gingiva / Perio _____ Oral Hygiene _____ BTSD _____

TMJ Exam WNL / DYSFX Open _____ Right _____ Left _____ Protrusion _____ Deviation R / L

Opening Click Pop SubLux _____ RIGHT Early Mid Late _____ LEFT Early Mid Late

Closing Click Pop Sublux _____ RIGHT Early Mid Late _____ LEFT Early Mid Late

Pain _____ Symptoms _____ Working Side Interferences: _____ Non-Working Side Interferences: _____

F / D = _____

Lip Length / Incisal Show / @ Rest & Smiling

Comments: _____ Ankyloglossia N1 N2 N3 N4 DMFS + ++

RECALL: _____ months RECORDS: iCat Adult / Child / Progress Photos Anatomodels Plus

OFS OFS

Date: _____ Will Call HWF OM x 2 SM x 2 MTS x 2 x 4 (Sam2) BP

Initial Exam with _____ EST FEES: Tentative Treatment Plan Options &

Limitations

