REEN & WILLCUTTS ORTHODONTICS

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ADULT ORTHODONTIC CONSULTATION FORM

Name of Patient_____ Sex ____ Birthdate_____ Age _____

Street_____ Town _____ State _____ Zip Code_____

Tel._____ Cell Phone_____ E-mail_____

Family Dentist_____ Family Physician _____

Name and Address of Person Responsible for Payment of Account _____

Dental Insurance _____ Employer_____

Referred to this office by _____ Family Members Treated _____

MEDICAL HISTORY

Diabetes	____	Anemia	____	Prolonged Bleeding	____
Rheumatic Fever	____	Bone Disorders	____	Fainting or Dizziness	____
Tuberculosis	____	Pneumonia	____	Tonsils Removed	____
Epilepsy	____	Heart Disorders	____	Adenoids Removed	____
Asthma	____	Endocrine Problems	____	Hepatitis	____
Nervous Disorders	____	Arthritis	____	Other_____	____

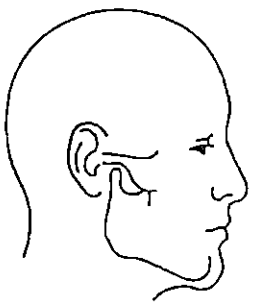
	Yes or No
Are you in good health? _____	_____
Are you under a physician's care? Reason _____	_____
Are you taking any drugs or medications? List _____	_____
Do you have any **allergies** or **drug sensitivities?** List_____	_____
Do you have a history of major illness? List _____	_____

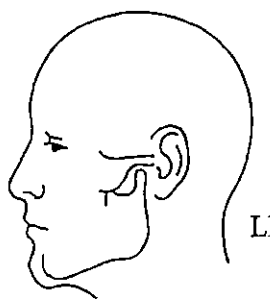
DENTAL HISTORY

	Yes or No
Have you had any injuries to the Face ____, Chin____, Mouth ____, or Teeth____ ? _____	_____
Do you breathe predominantly through the mouth? _____	_____
Do you have any speech problems? _____	_____
Have you had previous orthodontic consultation/treatment _____, Teeth or Bite Adjusted _____? _____	_____
Do you have any problems with your jaw? Started when? _____	_____
Pain? - R___L___, Clicking? - R___L___, Popping? - R___L___, Grinding? - R___L___ _____	_____
Is the pain worse in the morning after rising or interfere with your daily routine? _____	_____
Are you aware of anything that makes your pain worse? List _____	_____
Do you do or take anything now to relieve your pain? List _____	_____

On the figures below: Mark an **X** where you have pain, **circle the X** where most severe.

RIGHT





LEFT

Do you suffer from Headaches____, Neck Pain ____, Shoulder Pain ___? Mark an **H** on the Figure Above where you experience headaches.	_____
Has your jaw ever locked Open____, Closed ____, or Partly Closed ___? When did this occur and how often has it occurred. _____	_____

Please continue on back.

Patient's Name _____ Date _____

Yes or No

Have you ever injured your jaw? When and how? _____ _____
Do you grind _____ or clench _____ your teeth? _____ _____
Has anyone heard you grinding your teeth during sleep or are you aware that you do? _____ _____
Do you have any of the following symptoms upon awakening in the AM? _____ _____
Stiff jaw ____, Sore jaw or teeth ____, Cracking or locked jaw ____, Headaches _____ _____
Is your jaw tired or sore after chewing gum or chewy foods? _____ _____
Have you had nervous Stomach ____, Ulcers___, Bowel Trouble ____, Colitis ____? _____ _____
Are you under more stress than most people or been through a recent stressfull period? _____ _____
Please explain _____ _____
Please provide any additional information you feel may be helpful in the diagnosis or treatment of your condition. _____

Date _____ Patient's Signature _____

Medical history reviewed: _____ Date _____

Date _____ Date _____ Date _____

EXAMINATION CARD

1. Angle Classification

	Right Side		Left Side	
	Molar	Cuspid	Molar	Cuspid
Class I				
Class II				
Div II				
Class III				

2. Dentition

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

3. Arch Length - Max - Excess___ Adequate ___ Deficient ___ Amt. ___mm
Man - Excess ___ Adequate ___ Deficient ___ Amt. ___mm
4. 321 / 123 Crowded ___ Even___ Spaced ___ Amt. ___mm
321 / 123 Crowded ___ Even___ Spaced ___ Amt. ___mm
5. Crossbite - Right __ Left __ Ant. __ BiMax. __ Max. Buccal __ Max. Lingual __
6. Overbite - Normal ___ Moderate ___ Deep ___ _____%
7. Openbite - Ant. ___ Bilat. ___ Right ___ Left___ Amt. ___mm
8. Overjet - Edge to Edge ___ Normal ___ Excessive ___ Amt. ___mm
9. Curve of Spee - Deep ___ Normal ___ Flat ___ Reversed ___
10. Median Line - Max Midline to Mid-Sagital _____|_____
Man Midline to Rest _____|_____ Occlusion _____|_____
11. Path of Closure - Unrestrictive ___ Contact and Mesial ___ Contact and Distal ___
Contact Right ___ Contact Left ___ Pseudo Class III ___
12. TMJ - Clicks ___ R / L Crepitus ___ R / L Pain ___ R / L Time Duration _____
13. Range of Motion - Wide Open ___mm Right Lateral ___mm Left Lateral ___mm
14. Wide Open Lock___ Partly Closed Lock___ Closed Lock___
15. Headaches ____ R / L / F Neck & Shoulder Pain ____ Myofacial Pain___ R / L
16. Lip Posture - Together Relaxed ___ Together Strained ___ Apart ___
17. Lip Muscle Tone _ Hypo. ___ Normal ___ Hyper. ___
18. Abnormal Frenum - None___ Upper ___ Lower ___
19. Profile - Retrusive___ Concave ___ Flat ___ Protrusive ___ Double Protrusive ___ Satisfactory ___
20. Excessive Wear Facets - Anterior Teeth___ _ Posterior Teeth___
21. Oral Hygiene - Excellent___ Fair ___ Poor___
22. Patient's attitude toward treatment - Enthusiastic ___ Agreeable ___ Resentful___
23. Disposition of Case - Treat Now ___ Recall ___ ___Mos. No Treatment___
24. Notes. _____

C - Caries
X - Extracted
S - Supernumary
O - Congen Missing
A - Atypical Form
I - Impaction
D - Decalcification
R - Gin. Recession

DATE	