

KEITH T. SELLERS, D.D.S., M.S.

Welcome to our Office

Orthodontic Acquaintance Form

Adult

Patient Information

Date: _____

Acct.#: _____ Patient Name: _____ Preferred Name: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ Birthdate: _____ Email: _____ General Dentist: _____

Special Interests: _____ Name and ages of children: _____

Do you have Orthodontic Insurance? Yes No Policy Holder Name: _____ DOB: _____

SS#: _____ ID#: _____ Employer: _____

Whom may we thank for referring you to our office? Dentist _____ Patient/Friend _____

MEDICAL HISTORY

Physician's Name _____ Date of last physical exam _____

Is patient in good health? Yes No

Has patient ever been under the care of a physician for illness? Yes No

Please list _____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED.

Glaucoma..... <input type="checkbox"/>	Epilepsy..... <input type="checkbox"/>	High Blood Pressure..... <input type="checkbox"/>
Diabetes..... <input type="checkbox"/>	Asthma..... <input type="checkbox"/>	Low Blood Pressure..... <input type="checkbox"/>
Pneumonia..... <input type="checkbox"/>	Kidney Involvement..... <input type="checkbox"/>	Circulatory Problems..... <input type="checkbox"/>
Heart Trouble..... <input type="checkbox"/>	Endocrine Problems..... <input type="checkbox"/>	Radiation Treatment..... <input type="checkbox"/>
Rheumatic Fever..... <input type="checkbox"/>	Prolonged Bleeding..... <input type="checkbox"/>	Arthritis..... <input type="checkbox"/>
Bone Disorders..... <input type="checkbox"/>	Fainting or Dizziness..... <input type="checkbox"/>	Hepatitis..... <input type="checkbox"/>
Tuberculosis..... <input type="checkbox"/>	Nervous Disorders..... <input type="checkbox"/>	Malignancies..... <input type="checkbox"/>
Anemia..... <input type="checkbox"/>	Liver Involvement..... <input type="checkbox"/>	HIV/Aids..... <input type="checkbox"/>

Do you have tendency to colds? Sore Throats Ear Infections

Have tonsils and adenoids been removed? What age? _____ Yes No

Are you pregnant? Yes No

List any medications: _____ List any allergies: _____

Latex allergic? Yes No

DENTAL HISTORY

Have there ever been any injuries to the face, mouth, or teeth? Yes No _____

Have you ever sucked your fingers or thumb? Until what age? Yes No _____

Do you have any speech problems? Yes No _____

Are you a mouth breather? While awake? Yes No _____

While asleep? Yes No _____

Have you ever been informed of any missing or extra permanent teeth? Yes No _____

Have you ever consulted or been treated by an orthodontist previously? Yes No _____

Do you have pain in the jaw joints? Right Left Do you have popping or cracking of the jaw joints? Right Left

When did this begin? _____

Attitude toward orthodontic treatment: wants treatment treatment if necessary unwilling but agrees uncooperative

I authorize the release of any prior dental/medical records and give permission to use records in scientific presentations.

Authorized Signature _____

Initial Exam Report

Patient Name: _____

Patient #: _____ Date: _____

Letters: _____

Maxillary Profile

Orthognathic Max Prognathism
Max Retrognathia

Mandibular Profile

Orthognathic Mand Prognathism
Mand Retrognathia

Angle Classification

Class I Class II, Div 2
Class II, Div 1 Class III

Maxillary Arch

Normal Narrow
Wide

Mandibular Arch

Normal Narrow
Wide

Crossbite(s)

None Anterior
Anterior & Posterior Posterior

Max Incisor Position

Normal Flared & spaced
Crowded Tipped back
Flared Spaced

Mand Incisor Position

Normal Flared & spaced
Flared Tipped back
Crowded Spaced

Overbite

Normal Deep
Deep & Impinging Ant. Open Bite

Overjet

Normal Edge to edge
Excessive (mm) Slight

Midline

Impacted teeth

No Yes

Discolored, decalcified, defective teeth

Comment

TMJ Screening

Normal Not ideal/acceptable
Dysfunctional

Orthodontic Fee: _____ Treatment Time: _____ Recall: _____

Additional Notes: _____

What type of appliances

Full Partial (both arches)
Full (Max) Partial (Max arch)
Full (Mand) Partial (Mand arch)
Invisalign Partial (Invisalign)

Additional Treatment

Palatal Exp. Anterior Bit plate
Mand Exp. Pendulum
Herbst Quad Helix
Lip Bumper Nance

Additional Treatment II

Max surgery Mand surgery
Surgery both TPA
Facemask Splint therapy

Treatment Time

24 12-18
18-24 IP 6-12 Final 18-24
24-30 IP 12-18 Final 18
Less than 6 6 months
6-12 12 months
18 months

Possible extractions

Yes No Re-evaluate

Extraction comment

Full treatment at appropriate time

Yes No

Diagnostic Records

Taken today Recommended & sch.
Recommended & considered

Notes
