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

Welcome to our Office

Orthodontic Acquaintance Form

Patient Information **Date:**

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

Address: _____
Street City State Zip

Home Phone: _____ Hobbies: _____ School: _____

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

Responsible Party Information

Father _____ SS# _____ Mother _____ SS# _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Employer _____ Work# _____ Employer _____ Work# _____

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

Name and ages of children or other siblings _____

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 ☐	Epilepsy ☐	High Blood Pressure ☐
Diabetes ☐	Asthma ☐	Low Blood Pressure ☐
Pneumonia ☐	Kidney Involvement ☐	Circulatory Problems ☐
Heart Trouble ☐	Endocrine Problems ☐	Radiation Treatment ☐
Rheumatic Fever ☐	Prolonged Bleeding ☐	Arthritis ☐
Bone Disorders ☐	Fainting or Dizziness ☐	Hepatitis ☐
Tuberculosis ☐	Nervous Disorders ☐	Malignancies ☐
Anemia ☐	Liver Involvement ☐	HIV/Aids ☐

Does the patient have tendency to colds? ☐ Sore Throats ☐ Ear Infections ☐

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

Is patient 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 ☐	_____
Has patient ever sucked their fingers or thumb? Until what age?		Yes ☐ No ☐	_____
Does patient have any speech problems?		Yes ☐ No ☐	_____
Is patient a mouth breather?	While awake?	Yes ☐ No ☐	_____
	While asleep?	Yes ☐ No ☐	_____
Has patient ever been informed of any missing or extra permanent teeth?		Yes ☐ No ☐	_____
Has patient ever consulted or been treated by an orthodontist previously?		Yes ☐ No ☐	_____
Did either parent have orthodontic treatment?		Yes ☐ No ☐	_____

Does patient have pain in the jaw joints? Right ☐ Left ☐ Does patient have popping or cracking of the jaw joints? Right ☐ Left ☐

When did this begin? _____

Patient's 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.

Responsible Party 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

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

Any Comment

_____

_____

Notes

_____

_____

_____

_____

_____

_____

_____

Orthodontic Fee: _____ **Treatment Time:** _____ **Recall:** _____

_____ _____ _____

Additional Notes: _____ _____