NEW PATIENT FORM

Appointment date:____________ CASE#: _________________

Patient's Name: ___________________________________Preferred Name: ________________ Sex: M ☐ F ☐

DOB (mo/day/yr): _____ - _____ - _____ Age: ________ Patient's social security #: ___________________

Address: ____ ___________________
Street City Zip Phone #

E-mail address for appointment reminders: ____________________________________
(*parent e-mail if under 18*)

Family Dentist: ____

Referred to Orthodontists Associates by whom? ____

Patient's Physician: ____

*(**If treatment is for yourself**, please do not complete the " mother/father" information below. List your place of employment and work number. Please be sure to sign and date below.)*

Employer: ___________________________________ Work #: _____________ May we contact you at work? ______

Cell phone #: ________________________________

Parents: ☐ Married ☐ Divorced ☐ Deceased ☐ Other _____________

Father's name_____________________________
Home #: ___________ Cell #: ________________
Mailing Address:____________________________
____

Employer:___________________________________
Work #: ____________________________________
May we contact you at work ?__________________
Father's social security #: ___________________

Mother's name:_______________________________
Home #: ___________ Cell #: ___________________
Mailing Address: _______________________________
____

Employer: ____________________________________
Work #: ______________________________________
May we contact you at work? ___________________
Mother's social security #: _____________________

____ has completed the above on ________________.
Patient Signature (*Parent/guardian if minor*) date

**********For Office Use Only**********

ORTHODONTISTS ASSOCIATES OF WESTERN NEW YORK

Chief Concern: ____

____

Dental Classification ☐ I ☐ II-1 ☐ II-2 ☐ III

☐ Open Bite ☐ Deep Bite ☐ Crowding ☐ Spacing ☐ Crossbite

☐ Dental – U/L

☐ Skeletal – U/L

☐ Lower Facial Assymmetry – R/L

☐ Deviated Nasal Septum – R/L

☐ Dual Bite cr ________mm

Clinical Examination:

Missing Teeth

Decal

Caries

____

____

Gingival Condition: ☐ Normal ☐ Inflammation ☐ Hypertrophy

Oral Hygiene Evaluation: ☐ Good ☐ Fair ☐ Poor

Clinical Profile: ☐ Retrognathic U/L ☐ Orthognathic ☐ Prognathic U/L

☐ Retruded Lips ☐ Procumbent Lips

____

____

Musculature: ☐ Short Upper Lip ☐ Mentalis ☐ Peri-Oral Lip Strain

____

____

☐ Other ____

Habits: ☐ Thumb sucking ☐ Tongue-Thrusting ☐ Lip Sucking ☐ Mouth breather

____

____

TMJ: ☐ Symptomatic ☐ Asymptomatic

____

____

General Comments: ____

____

____

____

____