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Elite Premier Invisalign Provider
Orthodontics for Adults & Children

Patient/Child Information

Today's Date: ____/____/____

First & Last Name: _____

Birthday: ____/____/____ Age: ____

Home Address: _____

Dentist's First & Last Name: _____

Referred By: _____

Any other siblings seen by us: _____

Parent Information

FATHER

MOTHER

First & Last Name: _____

First & Last Name: _____

Social Security #: ____ - ____ - ____

Social Security #: ____ - ____ - ____

Birthday: ____/____/____

Birthday: ____/____/____

Home Address: _____

Home Address: _____

Home Phone #: (____) ____ - ____

Home Phone #: (____) ____ - ____

Work Phone #: (____) ____ - ____

Work Phone #: (____) ____ - ____

Cell Phone #: (____) ____ - ____

Cell Phone #: (____) ____ - ____

Patient's Medical History

Is patient in good health? Y/N Does Patient have any history of major illness? Y/N

Has patient been under the care of a physician for any illness in the last 12 months? Y/N

Please circles "Y" to any illness or disability for which the patient is undergoing treatment:

Diabetes	Y/N	Tuberculosis	Y/N	Endocrine Problems	Y/N
Anemia	Y/N	Prolonged Bleeding	Y/N	Heart Trouble	Y/N
Epilepsy	Y/N	Fainting/Dizziness	Y/N	Rheumatic Fever	Y/N
Asthma	Y/N	Nervous Disorders	Y/N	Bone Disorders	Y/N

Any other illness we should be aware of: _____

Does patient have tendency to: Colds Y/N Sore Throats Y/N Ear Infections Y/N

Have tonsils and adenoids been removed? Y/N At what age? _____

List any drugs/medications now being taken, and give reason: _____

List any allergies or drug sensitivities: _____

Has the patient reached puberty? Y/N Height: _____ Weight: _____

Any instruments played? _____ Is the patient involved in any other activities? _____

Patient's Dental History

Have there been any injuries to the face, mouth, or teeth? Y/N

Has the patient ever sucked a thumb or finger? Y/N Until what age? _____

Does the patient have any speech problems? Y/N

Is the patient a mouth breather? Y/N While awake OR sleeping? _____

Have you been informed of any missing permanent teeth? Y/N

Has either parent ever had orthodontic treatment? Y/N

Have you previously consulted an orthodontist? Y/N

Reason for consultation today? _____

Parent/Guardian Signature: _____

FOR OFFICE USE ONLY

Medical Summary Report Form

Name of Patient: _____

Examination Date: _____

Significant History: (Nature of Traumatic Injury OR Pertinent Past Medical History)

Traumatic injury as a result of: DESCRIPTION OF ACCIDENT/INJURY:

- Motor Vehicle Accident Date: _____
- Occupational Injury _____
- Accident Injury _____

Subjective Symptoms: At the time of initial examination, the patient reported the following complaints:

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Backaches (upper/lower) | <input type="checkbox"/> Facial Pain or Muscle Fatigue |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Neck aches or stiffness | <input type="checkbox"/> Referred Odontalgia (tooth pain) |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Difficulty opening/closing mouth | <input type="checkbox"/> Sore Throat or Gagging Sensation |
| <input type="checkbox"/> Tinnitus or Ringing in ears | <input type="checkbox"/> Inability to fully open the mouth | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Ear/Sinus Congestion | <input type="checkbox"/> Jaw clicking | <input type="checkbox"/> Eye Pain or Visual Disturbances |
| <input type="checkbox"/> Paresthesia in Fingertips | <input type="checkbox"/> Jaw/Joint Pain | <input type="checkbox"/> Frequent Stress |

Facial Survey:

Type: 1. Dolicho____ 2. Meso____ 3. Brachy____ Nose/Chin

Profile: 1. Straight____ 2. Convex____ 3. Concave____ Small Large Average

 4. B. Max____ 5. Asymmetric

Nose____ Lip Size____ (B Bulbous, T. Thin, S. Short) Lip Position/Function

Lip Tonicity____ Lip Size____ Lips Open____ Mentalis____

Chin____ Tongue Size____ Prenum____ Smile Line____ Strained Clefting Hypotonic/Hypertonic

Habits:

Mouth Breather____ Fingernail Biting____ Lip Biting____

Finger/Thumb-sucking____ Leaning chin or face____

Tongue Thrust____

Tonsils & Adenoids: None____ Normal____ Large____

Angle Classification and Relation of Segment:

<u>Profile</u>	<u>Molars</u>	<u>Cuspids</u>	<u>Overbite</u>	<u>Overjet</u>	<u>Missing Teeth</u>	
Straight ()	Class I ()	Class I ()	Open ()	Normal ()		
Convex ()	Class II ()	Class II ()	Normal ()	Mod ()		
Concave ()	Class III ()	Class III ()	Closed Mod ()	Severe ()		
	Sub R () L ()	Sub R () L ()	Severe ()			
<u>Crossbite</u>	<u>Arch Asymmetry</u>	<u>Midline Off</u>	<u>Crowding</u>	<u>Impacted Teeth</u>		
None ()	Max ()	Max ()	Max Mod ()	Severe ()		
Post ()	Mand ()	Mand ()	Mand Mod ()	Severe ()		
Ant ()		Right ()	Max Spacing ()			
		Left ()	Mand Spacing ()			
				Eruption Pattern		
				Early ()	Normal ()	Late ()

Initial Exam Date:_____ Fee:_____

FBT (Models) Date:_____ Fee:_____