*PLEASE PRINT*

# EVERETT RENGER, D.D.S., M.S., INC.

Specialist in Orthodontics

DATE ____________________

## WELCOME

The benefits of a pleasant, healthy smile are immeasurable! Our goal is to provide you with the very best and highest standards of orthodontic care. Thank you for your cooperation in completing information for both sides of this form.

## PATIENT INFORMATION

Name ______________________ (Last) ______________________ (First) ____________ (Middle) Sex: ☐ M ☐ F

Address ______________________ (Street) ______________________ (City) ________ (State) ________ (Zip)

Birthdate ______________ E-mail ______________________ Social Security # ______________________

Home Phone ______________ General Dentist ______________________ Last Visited ______________

Relatives, family members or friends treated here? ______________________________________________

Who may we thank for referring you to our office? ______________________________________________

## PARENTS INFORMATION

### FATHER

Name ______________________ (Last) ______________________ (First) ____________ (Middle) ____________ (Marital Status)

Address ______________________ (Street) ______________________ (City) ________ (State) ________ (Zip)

Birthdate ______________ E-mail ______________________ Social Security # ______________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________ ext. ______

Employer ______________________ Occupation ______________________ No. Years Employed ______

Relationship to Patient ______________________________

### MOTHER

Name ______________________ (Last) ______________________ (First) ____________ (Middle) ____________ (Marital Status)

Address ______________________ (Street) ______________________ (City) ________ (State) ________ (Zip)

Birthdate ______________ E-mail ______________________ Social Security # ______________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________ ext. ______

Employer ______________________ Occupation ______________________ No. Years Employed ______

Relationship to Patient ______________________________

## INSURANCE INFORMATION

Policy Owner's Name ______________________ Policy Owner's Employer ______________________

Insurance Company ______________________ Group No. (plan, local, or policy) ______________________

Insurance Co. Address ______________________________ Insurance Phone No. ______________________

Do you have Dual Coverage? ☐ Yes ☐ No

# CHILD PATIENT DENTAL / MEDICAL HISTORY

Please check ( ✔ ) Y or N on every item in all categories below – please feel free to ask for assistance if you do not understand a question.

☐ Yes ☐ No Is the patient in good health?

☐ Yes ☐ No Is the patient adopted?

☐ Yes ☐ No Has the patient's tonsils or adenoids been removed?

☐ Yes ☐ No Does the patient have any missing or extra permanent teeth?

☐ Yes ☐ No Has the patient ever had an injury to: (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Has the patient ever had any of the following habits:
☐ Lip Sucking/Biting ☐ Nail Biting ☐ Prolonged Bottle/Pacifier
☐ Clenching/Grinding Teeth ☐ Mouth Breathing
☐ Tongue Thrusting ☐ Thumb/Finger Sucking

☐ Yes ☐ No Does the patient have speech problems?
If Yes, explain ______________________________

☐ Yes ☐ No Does the patient play a musical wind instrument?
Which? ______________________________

☐ Yes ☐ No TMJ Pain (joint, ear or side of face)

☐ Yes ☐ No Frequent headaches

☐ Yes ☐ No Head or neck pain

☐ Yes ☐ No Difficulty opening or closing jaw

☐ Yes ☐ No Clicking or popping jaw

☐ Yes ☐ No Jaw locks open or closed

☐ Yes ☐ No Has the patient ever been evaluated for orthodontic treatment?

☐ Yes ☐ No Has the patient had previous orthodontic treatment?

☐ Yes ☐ No Has the patient had an unfavorable experience in a dental or medical office?

What are the main concerns that you would like orthodontics to accomplish? ______________________________
______________________________
______________________________

☐ Yes ☐ No Does the patient have any other dental/medical condition or problem that is not mentioned above? Please explain: ______________________________
______________________________
______________________________

☐ Yes ☐ No Is there any other information that would be helpful to us? Please comment: ______________________________
______________________________
______________________________

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that my child may need during diagnosis and treatment.

Signature ______________________________ Date ______________

# FOR DOCTOR'S USE ONLY

Angle Class: I ☐ II ☐ III ☐

Molar Relationship: R ______________ | ______________ L

Cuspid Relationship: R ______________ | ______________ L

Overjet Slight ☐ Moderate ☐ Severe ☐ ________ mm.

Overbite Slight ☐ Moderate ☐ Severe ☐ ________ mm.

Openbite Slight ☐ Moderate ☐ Severe ☐ ________ mm.

Max Arch: Normal ☐ Crowded ☐ Spaced ☐

Mand Arch: Normal ☐ Crowded ☐ Spaced ☐

Crossbite: Ant ☐ Post ☐ R ☐ L ☐

Arch Relationship: Normal ☐ Narrow Max ☐ Narrow Mand ☐
Wide Max ☐ Wide Mand ☐

Missing Teeth: R ______________ | ______________ L

Midline: Normal ☐ Max Shift to R ☐ L ☐
Mand Shift to R ☐ L ☐

Frenum: Normal ☐
Poss Surgery of: Max ☐ Mand ☐ Ling ☐

Hygiene: Good ☐ Fair ☐ Poor ☐

Facial Symmetry: Normal ☐ Asymmetry ☐

Facial Profile: Straight ☐ Convex ☐ Concave ☐

Extractions: Yes ☐ No ☐ Borderline ☐

Phase I ☐ Estimated treatment time ________

Phase II ☐ Estimated treatment time ________

Limited Tx ☐ Estimated treatment time ________

Notes: ______________________________
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