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 _____
If parents are divorced, will there be more than one billing party? If yes, please list:

Billing Party #1: _____

Father's name_____
Home #: _____ Cell #: _____
Mailing Address:_____
_____

Employer:_____
Work #: _____
May we contact you at work ?_____
Father's social security #: _____

Billing Party #2: _____

Mother's name:_____
Home #: _____ Cell #: _____
Mailing Address: _____
_____

Employer: _____
Work #: _____
May we contact you at work? _____
Mother's social security #: _____

Primary Dental Insurance
Policy Holder's name: _____
Carrier: _____
Group #: _____

Secondary Dental Insurance
Policy Holder's name: _____
Carrier :_____
Group #: _____

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

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

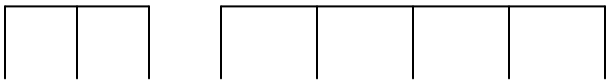
ORTHODONTISTS ASSOCIATES OF WESTERN NEW YORK, P.C.

Chief Concern: _____

_____

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

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



☐ Dental – U/L

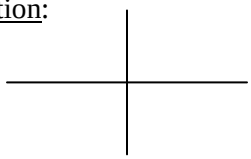
☐ Skeletal – U/L

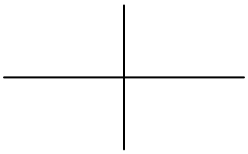
☐ Lower Facial Assymmetry – R/L

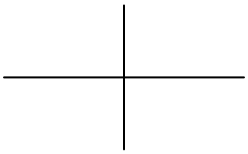
☐ Deviated Nasal Septum – R/L

☐ 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: _____

_____

_____

_____

_____

_____