

## NEW PATIENT EVALUATION - ADULT

### 1) PATIENT INFORMATION (please complete first 3 sections)

Last: \_\_\_\_\_, First \_\_\_\_\_, MI: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_, Age: \_\_\_\_\_ Sex:  Male  Female  
 Email address \_\_\_\_\_@\_\_\_\_\_  
 Home # (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell #(\_\_\_\_)-\_\_\_\_-\_\_\_\_ Work #(\_\_\_\_)-\_\_\_\_-\_\_\_\_

How did you hear about this office? \_\_\_\_\_  
 Emergency contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #(\_\_\_\_)-\_\_\_\_-\_\_\_\_

### 2) FINANCIAL INFORMATION

Person financially responsible for this account:  Parent;  Other Party; Name: \_\_\_\_\_  
 Billing address if different from custodial parent:  
 Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Dental insurance?  Yes  No; Covers Orthodontic Treatment?  Yes  No  
 Primary Policy Holder: Last: \_\_\_\_\_, First \_\_\_\_\_, MI: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years with Employer: \_\_\_\_\_  
 Employer's Address: Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Dental Insurance Company: \_\_\_\_\_, Group # \_\_\_\_\_, Policy# \_\_\_\_\_  
 SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (for insurance verification) Policy Holder DOB \_\_\_\_/\_\_\_\_/19\_\_

### 3) PROFESSIONAL INFORMATION

General dentist's name \_\_\_\_\_ Seen by dentist regularly? \_\_\_\_\_  
 Is this a transfer from another orthodontist? \_\_\_\_\_ Records being sent or available? \_\_\_\_\_  
 Orthodontist name \_\_\_\_\_, City \_\_\_\_\_ State \_\_\_\_\_ Phone# \_\_\_\_\_

Any allergies (latex or metals) or chronic health problems? \_\_\_\_\_  
 What is your primary orthodontic concern? \_\_\_\_\_



### 4) ORTHODONTIC TREATMENT NEEDS

DATE \_\_\_\_/\_\_\_\_/200\_\_

Missing Teeth or Imp	R			L	Overjet	WNL	Excess ____ mm	Under ____ mm				
						L Molar: I, E, II, III	R Molar: I, E, II, III	Skeletal: I, II, III				
Crossbites	R			L	Crowding	Max	WNL	Space	Crowded	≤3	≤6	≤9
						Man	WNL	Space	Crowded	≤3	≤6	≤9
Vert Bite	%deep	mm open	Dental	Skeletal								

Restorative/periodontal needs \_\_\_\_\_  
 Notes: \_\_\_\_\_  
 Probable Treatment Plan: \_\_\_\_\_  
 Appoint for:  Phase 1 Records  Comprehensive Records  Recall Mo \_\_\_\_ Yr 200\_\_

F/U letter to pt \_\_\_\_/\_\_\_\_/200\_\_  F/U letter to dentist \_\_\_\_/\_\_\_\_/200\_\_

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