

# WELCOME

to



## NEW PATIENT EVALUATION - CHILD

### 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 #(\_\_\_\_)-\_\_\_\_-\_\_\_\_  
 School \_\_\_\_\_  
 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 or chronic health problems? \_\_\_\_\_  
 What is your primary orthodontic concern? \_\_\_\_\_



### 4) ORTHODONTIC TREATMENT NEEDS

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

Dentition Stage: Primary; Early - Mixed – Late Growth phase: pre peak post complete

Missing Teeth or Imp	<table border="1"> <tr><td>R</td><td></td><td>L</td></tr> <tr><td></td><td></td><td></td></tr> </table>			R		L				Overjet	WNL	Excess __ mm	Under __ mm			
	R		L													
Crossbites	<table border="1"> <tr><td>R</td><td></td><td>L</td></tr> <tr><td></td><td></td><td></td></tr> </table>			R		L				L Molar: I, E, II, III	R Molar: I, E, II, III	Skeletal: I, II, III				
	R		L													
Crowding				Max	WNL	Space	Crowded	≤3	≤6	≤9						
				Man	WNL	Space	Crowded	≤3	≤6	≤9						
Vert Bite	%deep	mm open	Dental	Skeletal												

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\_\_

Mark J. Bentele, DDS, MS