

6243 South Redwood Road, Suite 240
Salt Lake City, Utah 84123
Telephone 801-263-1333

7050 South Highland Drive, Suite 210
Salt Lake City, Utah 84121
Telephone 801-943-6666

Patient # _____

PATIENT INFORMATION

GENERAL INFORMATION

Patient name _____ Birthday _____ Date _____
Home address _____ City/State/Zip _____ Age _____
Financially responsible party _____ SS# _____
Address _____ City/State/Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ How long employed? _____
Marital Status [] S [] M Spouse Name _____ Spouse Work Phone _____
Whom may we thank for referring you? _____
Has any other member of the family had orthodontic treatment? [] Yes [] No Relationship _____
Has any other member of your family been treated in our office? [] Yes [] No
Names of family members treated _____
Favorite hobby/sport _____

MEDICAL HISTORY

How is patient's general health? _____
Are the tonsils and adenoids still present? [] Yes [] No
Has there been any history of diabetes, rheumatic fever, tuberculosis, kidney or liver ailments, epilepsy? [] Yes [] No
If "yes", describe _____
Are there any allergies (sulfa, penicillin, other)? Describe _____
What medical and dental x-rays have been taken in the last year? _____
Is the patient under the care of a physician at present? [] Yes [] No
If yes, for what reason? _____
Are any medications being taken? Describe _____

DENTAL HISTORY

Patient's Dentist _____ Last dental checkup? _____
Age of first baby tooth. _____ Has the patient ever suffered any blow or injury to face or teeth? [] Yes [] No
Please describe _____
Does the patient clench or grind the teeth at night? [] Yes [] No / Did the patient suck his/her thumb? [] Yes [] No
Does patient breathe through the mouth or are the lips often parted? [] Yes [] No
Who first noticed the need for orthodontic treatment? _____
Is the patient concerned about the appearance of the teeth? [] Yes [] No
What would you most like to have orthodontics accomplish? _____

GROWTH INFORMATION

Has the patient shown signs of pubertal development? [] Yes [] No
If female, has the patient begun her monthly period? [] Yes [] No If "yes", age began _____
At what age did the patient show the greatest height increase? _____

ORTHODONTIC INSURANCE INFORMATION

Primary Dental Insurance Co. _____ Group# _____
Address. _____ Phone # _____
Insured Person's Name. _____ Employer _____
SS# _____ Birthday _____
Secondary Dental Insurance Co. _____ Group# _____
Address. _____ Phone # _____
Insured Person's Name. _____ Employer _____
SS# _____ Birthday _____

I understand that Dr. Maxfield's office submits insurance claims to my insurance company as a courtesy. However I am responsible for any balance not paid by insurance.

I understand that appointments will infringe on school time during orthodontic treatment. (It should be an excused absence.)

I understand that where appropriate a credit report may be obtained.

To the best of my knowledge, the above information is correct as of this date.

SIGNATURE OF RESPONSIBLE PARTY _____

OFFICE ACTION

Call back _____ PWCB _____ Recall _____ CP _____ Ext _____ Start reg _____ RPE _____
CR _____ Est Fee \$ _____ Est Ins _____ Dwn _____ Monthly _____
Est tx time _____ Imp _____ Records _____
CP _____ SW _____ IB _____ LB _____

NP NOTES

Recall _____

Phase I _____

Phase II or Full Tx _____

CLASSIFICATION

Skeletal I II III
Dental I II₁ II₂ III

- Deep bite
- Skeletal deep bite
- Open bite
- Skeletal open bite
- Crossbite
- Crowding
- Maxillary constriction
- Missing teeth —|—
- Impacted teeth —|—
- Surgery
- Tongue thrust
- Perio
- TMJ
- Spacing

TREATMENT PLAN

- Full and Comprehensive
- Non extraction
- Early Phase I
- Extractions —|—
- Upper Arch only
- Possible later extractions —|—
- Headgear
- Elastics
- RPE
- Surgery
- Retainer
- LA
- TPA
- BP
- Bionator
- TMJ Splint
- Quad
- Functional app
- Tongue therapy
- Pendulum