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DIAGNOSTIC TREATMENT CHART

Patient's Name_____

Patient's Address_____

Phone #_____ SS#_____

Birth Date_____ Age_____ Sex_____

Occupation_____ Hobby_____

Patient's Dentist_____ Patient's physician_____

Father's Name_____ Occupation_____

Address_____

Employed by_____ Business phone_____

Insurance Company_____ ID #_____ Group #_____

Address_____

Mother's Name_____ Occupation_____

Address_____

Employed by_____ Business phone_____

Insurance Company_____ ID #_____ Group #_____

Address_____

Person Responsible for this account_____

PATIENT INFORMATION

Whom may we thank for referring you to our office?_____

Name of nearest relative not living with you_____

Phone #_____

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE PAST 9 MONTHS

Practitioner	Specialty	Approx. date of treatment
_____	_____	_____
_____	_____	_____

PATIENT HISTORY

Patient Health	Good	Fair	Poor
Under Treatment	Yes	No	
Drugs or Medication	Yes	No	

MEDICAL HISTORY

HAS PATIENT EVER HAD?

Y N Abnormal Bleeding
Y N Adenoids or Tonsils Removed
Y N Allergies to: Plastic Latex Metals
Y N Allergies to Medications_____
Y N Allergies, other_____
Y N Asthma
Y N Autoimmune Disorders
Y N Bleeding Gums
Y N Blood Pressure: High Low
Y N Blood Sugar: High Low
Y N Convulsions / Epilepsy
Y N Cancer
Y N Diabetes
Y N Dizziness
Y N Endocrine disorders
Y N Facial pain
Y N Headaches
Y N Hearing Impairment
Y N Heart Murmur
Y N Heart Disorder, Other_____
Y N Hepatitis
Y N Hemophilia
Y N HIV+/AIDS
Y N Injury to Face, Teeth or Mouth?
Y N Jaw Pain
Y N Kidney Problems
Y N Muscle Aches
Y N Neck Pain
Y N Operations/Hospital stays
Y N Rheumatic Fever
Y N Ringing of the Ears
Y N Shortness of Breath
Y N Sinus Problems
Y N Snoring
Y N Tendency for: Colds
Ear Infections
Sore Throats
Y N Taking Medications
Y N Prior Orthodontic Treatment
Y N Clenching/Grinding Teeth
Y N Lip Biting
Y N Nail Biting
Y N Mouth Breather
Y N Speech Difficulties
Y N Thumb/Finger sucking,
Age?_____
Y N Play musical instrument
Y N Consulted another dentist for Orthodontic evaluation?
Y N If child, has he/she reached puberty?

Past Medical History, Explain:_____

MEDICATIONS CURRENTLY BEING TAKEN

Y	N	Antibiotics	Y	N	Insulin
Y	N	Anticoagulants	Y	N	Muscle relaxants
Y	N	Barbiturates	Y	N	Nerve pills
Y	N	Blood thinners	Y	N	Pain medication
Y	N	Codeine	Y	N	Sleeping pills
Y	N	Cortisone	Y	N	Sulfa drugs
Y	N	Diet pills	Y	N	Tranquilizers
Y	N	Heart medication			

Other:_____

Have tonsils or adenoids been removed?	Yes	No	What age?
Tendency for colds?	Yes	No	
Sore throats?	Yes	No	
Ear infections?	Yes	No	
Tubes in ears?	Yes	No	What age?

REASON FOR VISIT

_____Accident	_____Mismatched bite
_____"Buck" or protruding teeth	_____Missing tooth
_____Clicking of jaw joint	_____Missing teeth
_____Crowded teeth	_____Neck pain - frequent
_____Facial pain	_____Orthodontic-2nd opinion
_____Gum Disease or Recession	_____Overbite
_____Head pain	_____Overly small mouth
_____Irregular facial proportions	_____Prominent jaw
_____Irregularly shaped teeth	_____Receded jaw
_____Jaw dysfunction	_____Tooth spacing - Excessive
_____Jaw Pain	_____Other, explain_____

DENTAL HISTORY

Has the patient ever sucked their thumb or finger?	Yes	No	Until what age?
Has the patient acquired any speech problems?	Yes	No	
Does the patient breathe through the mouth?	Daytime	Nighttime	No
Has either parent had previous orthodontic treatment?	Yes	No	
Has the patient played any musical instruments?	Yes	No	When?
Have you consulted an orthodontist or another Dentist regarding your orthodontic problem?	Yes	No	

What is the patient's chief concern?_____

Values clarification __Aesthetics __Function __Improved Health __Other

I understand that the information that I have given is correct to the best of my knowledge. I authorize the dental staff to perform necessary dental services. I authorize the release of written records to any referring or treating dentist or physician, insurance company or for legal documentation. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage and that prior to extending credit for treatment fees; the dental office reserves the right to verify the credit status of potential patients and/or parents of patients and may use the services of credit reporting bureaus.

_____ _____

Signature of Patient, Parent or Guardian Date

FOR OFFICE USE ONLY

Initial Consultation Appt: Date_____ In Attendance_____

Final Consultation Appt: Date_____ In Attendance_____

Informed Consent: Date reviewed_____ Date Signed_____

Treatment Agreement: Phase I Date_____ Phase II Date_____

Insurance Letter Required: Y N Letter Written _____ Reply received_____

RECORDS	INITIAL	PROGRESS	COMPLETED
Diagnostic Chart	_____	_____	_____
Perio Exam	_____	_____	_____
Photos	_____	_____	_____
Cephalometric X-Ray	_____	_____	_____
Cephalometric Tracing	_____	_____	_____
Panorex	_____	_____	_____
Periapical	_____	_____	_____
Tran cranial	_____	_____	_____
Study Models	_____	_____	_____
TMJ Exam	_____	_____	_____
JVA	_____	_____	_____

CLASSIFICATION OF MALOCCLUSION:

Dentally	Class I	Class II	Class III	Div. 1 2
(Study Models)	Open	Average	Closed	
	Deciduous	Mixed	Permanent	
Skeletally	Class I	II	III	
(Radiographic)	Open	Average	Closed	
Profile	Soft Tissue S-Line		Upper_____mm	
	(Middle of Nose-Chin)		Lower_____mm	
	Lips	Convex	Concave	
	Straight	Retrognathic	Prognathic	

SUMMARY OF CLINICAL FINDINGS

Molar Relationship	R L	Cuspid Relationship	R	L
Overjet _____ mm	Large, Moderate, Normal, Negative			
Overbite _____ mm	Palatal, Deep, Normal, Open			
Crossbite	Anterior, Posterior, Teeth #'s:			
Crowding	Anterior, Posterior, Teeth #'s:			
Spacing	Teeth #'s:	Diastema	Teeth #'s:	
Missing teeth	Damaged teeth	Impacted teeth	Devitalized	Attrition
Malformed teeth	Supernumary teeth	Marked teeth	Accidents	
Labial frenum	Normal	Heavy		
Frenectomy	Yes	No	Future	
Tonsils	Enlarged, inflamed, normal		R 1 2 3 4	L 1 2 3 4
Adenoids	Normal	Enlarged	Ceph Measurement _____mm	
Rate of caries	High	Moderate	Low	
Gingiva	Health, Gingivitis, Bleeding, Hypertrophic, Recessed			
Periodontal Condition	Excellent	Average	Poor	
Fibrotomy	Teeth #'s:			

Size of Teeth	Anterior	Small	Normal	Large	
	Posterior	Small	Normal	Large	
Curve of Spee	Excessive	Moderate	Normal	Flat	
Dental Midline	Maxillary	Shifted Right _____ mm	Normal	Shifted Left _____ mm	
	Mandibular	Shifted Right _____ mm	Normal	Shifted Left _____ mm	
Arch Length	Maxillary	Excessive	Adequate	Deficient	Amount____mm
	Mandibular	Excessive	Adequate	Deficient	Amount____mm
MX Arch Form	Narrow	Ovoid	Wide	Symmetrical/Asymmetrical	
MD Arch Form	Narrow	Ovoid	Wide	Symmetrical/Asymmetrical	
Protrusions	Maxillary_____		Mandibular_____		

External appearance	Walk	Normal	Abnormal		
	Sitting	Normal	Abnormal		
	Posture	Normal	Abnormal		
Muscle Pattern:	Tongue	Small	Normal	Large	Thrust
	Tongue Trust	_____Anterior	_____Posterior		
	Mandibular Lip	Loose	Normal	Tight	
	Maxillary Lip	Loose	Normal	Tight	
	Cheeks	Loose	Normal	Tight	
Habits	Breathing	Normal	Mouth breather		
	Thumb	Normal	Thumb sucker		
	Swallowing	Normal	Reverse		
	Mentalis	Normal	Tight		
	Submental crease	Normal	Slight	Large	
	Lips	Normal	Incompetent		
	Finger habit	_____Yes	_____No		
	Finger nail biting	_____Yes	_____No	Lip Biting _____Yes	_____No
	Speech habit	_____Yes	_____No	Lisp _____Yes	_____No
Mandibular Plane	Steep	Normal	Flat		
	Chin Point	Flat	Normal	Button	
Facial Type	Dolicho	Meso	Brachy	Bimax	
	Profile	Straight	Retrognathic	Prognathic	
	Maxilla	Normal	Retrognathic	Prognathic	
	Mandible	Normal	Retrognathic	Prognathic	
Frontal	Asymmetrical	Right	Left		
Lips	Shape	MX Lip Thin	Average	Full	
	Shape	MD Lip Thin	Average	Full	
	Lip Tonicity	Hypertonic	Hypotonic	Normal	
	Smile Line	Average	Excessive	Minimal	
	Gummy Smile	Yes	No	_____mm	
	Lower Face Height	Normal	Long	Short _____mm	

TMJ HEALTH QUESTIONARRE

CHIEF CONCERN_____
DATE OF ONSET_____

PAIN SYMPTOMS

Do you ever get “tension headaches”?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you ever get “migraine headaches”?	Y	N			
Do you frequently have neck aches or stiff neck muscles?	Y	N	Do you get headaches in the back of your head?	Y	N
Do you have trouble sleeping soundly?	Y	N	Do you grind your teeth when asleep?	Y	N
Have your teeth been sore upon awakening?	Y	N	Are your jaws tired when you awaken from sleep?	Y	N
Does your jaw ache when you chew?	Y	N			
Do you have ear pain?	Y	N	When are your symptoms the worst?_____		
Does your jaw ache when you open wide?	Y	N	_____		
Have you ever had chronic shoulder or back pain?	Y	N	Does anything make you feel better?_____		
			_____		
What medications, if any, are you taking?			Have your wisdom teeth been extracted?	Y	N
_____			Details_____		
_____			_____		

How often do you take medicine for relief of pain?
A) Never B) Weekly to Monthly
C) Weekly D) Daily

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw?	Y	N	Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Any whiplash neck injuries?	Y	N	Details_____		

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal?	Y	N	Do you feel or hear a clicking, popping, or cracking noise from either jaw joint:?	Y	N
Are there any foods you avoid eating?	Y	N			
Do you ever get dizzy?	Y	N	Has you jaw ever locked where you were unable to close or open?	Y	N
Do you ever feel faint?	Y	N			
Do you feel nauseated (sick)?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N	Have you ever had pain in either jaw joint?	Y	N

EYE AND EAR SYMPTOMS

Do you have itchiness or stuffiness in either ear?	Y	N	Do you hear ringing, buzzing or hissing sounds in either ear?	Y	N
Do you suffer from any loss of hearing?	Y	N			
Do you get pain in, around or behind either eye?	Y	N	Do you hear grating noises in ears? (like sand particles rubbing)	Y	N
Are there times when your eyesight blurs?	Y	N	Do you wear glasses or contacts?	Y	N

BREATHING

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have a sinus problem?	Y	N			
Do you snore at night?	Y	N			

TMJ EXAMINATION

RANGE OF MOTION MEASUREMENTS
Maximum Interincisal Opening

Maximum Opening _____mm + Overbite _____ mm = _____ mm.
Maximum Opening _____mm - Overbite _____ mm = _____ mm.

Right Lateral Movement _____mm.
Left Lateral Movement _____ mm.

Protrusive Movement _____ mm. + Overjet _____ mm. = _____ mm.
Deflection/Deviation to Left on opening.
Deflection/Deviation to Right on opening.
No Deviation/Deflection

JOINT PALPATION

No pain	No clicking	No crepitus	No popping
Pain on Left	Clicking on Left	Crepitus on Left	Popping on Left
Pain on Right	Clicking on Right	Crepitus on Right	Popping on Right

MUSCLE PALPATION

✓=No Pain X=Uncomfortable O=Pain OO=Severe pain

Date	_____		_____		_____	
	Initial		**Update**		**Final**	
Extra-Oral	**Right**	**Left**	**Right**	**Left**	**Right**	**Left**
Posterior TMJ	_____	_____	_____	_____	_____	_____
Vertex	_____	_____	_____	_____	_____	_____
Sinus	_____	_____	_____	_____	_____	_____
Occipital	_____	_____	_____	_____	_____	_____
Posterior neck	_____	_____	_____	_____	_____	_____
Trapezius	_____	_____	_____	_____	_____	_____
Anterior Digastric	_____	_____	_____	_____	_____	_____
Posterior Digrastic	_____	_____	_____	_____	_____	_____
Sternocleidomastoid	_____	_____	_____	_____	_____	_____
Anterior Temporalis	_____	_____	_____	_____	_____	_____
Medial Temporalis	_____	_____	_____	_____	_____	_____
Posterior Temporalix	_____	_____	_____	_____	_____	_____
Superficial Masseter	_____	_____	_____	_____	_____	_____
Deep Masseter	_____	_____	_____	_____	_____	_____
Intra-Oral						
Masseter Body	_____	_____	_____	_____	_____	_____
Lateral Pterygoid	_____	_____	_____	_____	_____	_____
Medial Pterygoid	_____	_____	_____	_____	_____	_____
Range of Motion						
Maximum Opening	_____	_____	_____	_____	_____	_____
Right Lateral Movement	_____	_____	_____	_____	_____	_____
Left Lateral Movement	_____	_____	_____	_____	_____	_____
Protrusive Movement	_____	_____	_____	_____	_____	_____
Deflection /Deviation on Opening	_____	_____	_____	_____	_____	_____
Clicking on Opening	_____	_____	_____	_____	_____	_____
Pain on opening	_____	_____	_____	_____	_____	_____

MODIFIED HARVOLD ANALYSIS:

Mandibular Length	_____ mm. (condylion to gnathion)		
Maxillary Length	_____ mm. (condylion to A pt.)		
MX-MD Difference	_____ mm.		
MX Length	_____ mm.	MX Length	_____ mm.
MD Length	_____ mm.	ANS-M	_____ mm.
Ideal MD Length	_____ mm.	Ideal ANS-M	_____ mm.
Difference	_____ mm.	Difference	_____ mm.