Date _____ Case # _____

Patients Name _____ Sex _____

Address _____ City _____ Phone No. _____

Age _____ Birth Date _____ Grade _____ School _____

Person responsible for account - Name _____

Occupation _____

Business Address _____ Phone No. _____

Dentist _____ Physician _____

Referred by _____ Date of last Dental Exam. _____

Chief Complaint _____

Do you have orthodontic insurance? _____

Number of children in family _____

Anyone else in family have similar condition? _____

Any baby or permanent teeth removed by your dentist? _____

Has patient had orthodontic treatment before? _____

MEDICAL HISTORY: Height _____ Weight _____

Heart _____ Rheumatic Fever _____

Tonsils or Adenoids removed _____ General Health _____

Any Major Illness or Hospitalization _____

HABITS: Mouth Breathing _____ Finger _____

Nail Biting _____ Other _____

DIAGNOSIS AND OBSERVATION: _____

_____

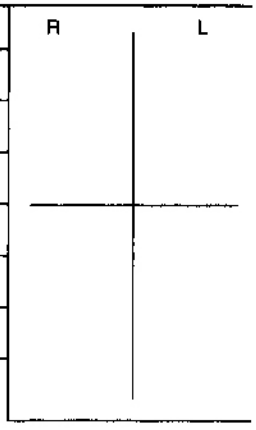
_____

RECOMMENDATIONS: _____

_____

_____

FEE: _____ Estimated Treatment Time _____



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