



Heather A. Lindsay

D D S • M S
ORTHODONTICS

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The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

1. About You

Today's Date _____

Name _____

Name Preferred _____ Male Female

Birth Date _____ Age _____

Married Divorced Separated Single Widowed

SS# _____

Home Ph. _____ Cell/Other _____

Work Ph. _____ Email _____

Employer _____

Employer's Address _____

How long there? _____ Occupation _____

When and where are the best times to reach you? _____

Other family members seen by us _____

Relationship _____

Dentist _____

Last visit date _____

2. Spouse Information

Name _____

Employer _____

Work Ph. _____ Ext _____ SS# _____

Birthdate _____

3. Person Responsible for Account

Name _____ Relation _____

Billing Address _____

City, State, Zip _____

Work Ph. _____ Ext _____ Home Ph. _____

Employer _____

SS# _____ Date of Birth _____

4. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Phone No. _____

Insured's Name _____

Relationship to Patient _____

Insured's Birth date _____ SS# _____

Insured's Employer _____

5. Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician: Yes No

Please explain _____

Please discuss any serious medical problems that you have had:

Are you allergic to any of the following drugs?

- | | |
|----------------------------------------------------------|----------------------------------------------------------------|
| <u>Yes/No</u> | <u>Yes/No</u> |
| <input type="radio"/> <input type="radio"/> Penicillin | <input type="radio"/> <input type="radio"/> Dental Anesthetics |
| <input type="radio"/> <input type="radio"/> Aspirin | <input type="radio"/> <input type="radio"/> Codeine |
| <input type="radio"/> <input type="radio"/> Erythromycin | <input type="radio"/> <input type="radio"/> Latex |
| <input type="radio"/> <input type="radio"/> Tetracycline | <input type="radio"/> <input type="radio"/> Other |

List any other drugs that you are allergic to

List any medications you are currently taking

- | | |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <u>Yes/No</u> | <u>Yes/No</u> |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizure/Fainting |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Diabetes/Tuberculosis (TB) |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> <input type="checkbox"/> Hemophilia/Abnormal Bleeding |
| <input type="checkbox"/> <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Asthma/Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> <input type="checkbox"/> Sinus Problems | |

8. Dental History

Why have you come to the orthodontist today?

Your current dental health is: Good Fair Poor

Yes/No

- Are you currently in pain?
- Have you ever had a serious/difficult problem associated with any previous dental work?
- Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
- Do you like your smile?
- Do your gums ever bleed?

Who may we thank for referring you to our office?

Signature

Date

Office Use Only

Office Use Only

Office Use Only

	Jaw	RIGHT SIDE		LEFT SIDE	
		Molar	Cuspid	Molar	Cuspid
Class I					
Class II					
Div.I					
Div.II					
Class III					

Oral Hygiene Excellent Good Fair Poor

TMJ Normal Popping/Crepitus L/R Pain/L/R

Lip/Muscle Posture Lip Strain Mentalis Strain

Arch length:

Upper Excess Adequate Deficient _____mm

Lower Excess Adequate Deficient _____mm

Overbite Deep Normal Open _____%

Overjet _____mm

Habits Tongue thrust Thumb/finger

Mouthbreathing

Abnormal frenum Upper Lower

Probable Extraction Non-Extraction Borderline

Crossbite: R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Midline R _____ L

Deciduous Teeth R _____ E D C B A | A B C D E _____ L
E D C B A | A B C D E

Missing

Permanent Teeth R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L
R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 L

Notes: _____

Recommendation: Treat Now _____
 Recall: 3 mo. 6 mo. 1 yr.
 No treatment

Estimated Tx Time _____ Months _____ Fee

U/L Clarity _____

U/L Invisalign _____

Next Appt: _____

Letters:

Records TBD Wait for TX NC TY Re FU Pt