Northside Orthodontics

Christopher J. Getchell, D.D.S.

Date _____

Patient's Name_____Nickname_____

Date of Birth _____ Age _____ Sex _____

Address _____ City _____ Zip Code_____

Home Phone _____

Cell Phone _____ Email address _____

Father's Name _____Occupation _____

Employed By _____

Business Phone _____

Mother's Name _____ Occupation _____

Employed By _____

Business Phone _____

Parents' Marital Status: Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐

Person assuming financial responsibility for orthodontic treatment _____

Address (if different) _____

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

Patient's current Dentist _____

Patient's attitude toward Orthodontic Treatment? Favorable ☐ Indifferent ☐ Negative ☐

Ages of Patients Brothers _____ Sisters _____

Progress in School Above Average ☐ Average ☐ Having Difficulty ☐

Has Patient had excessive thumb sucking? Yes ☐ No ☐ Nail Biting? Yes ☐ No ☐

Temperament of Patient Usually? Nervous ☐ Active ☐ Quiet ☐

Has patient received previous orthodontic treatment or consultation? Yes ☐ No ☐ When? _____

Main Interest/Activities (sports, hobbies) _____

Do You Have Orthodontic Insurance? ☐Yes ☐ No Insurance Policy _____

Name of Insured (if different) _____

Social Security Number of Insured _____ Date of Birth of Policy Holder_____

For Doctor's Use

Profile:	st concave convex	Hygiene:	good fair poor
Lip muscle tone:	wnl hyper hypo	Gingiva:	wnl
Smile line:	coincident non	Habits:	none th tg brux
Incisal length:	mm	Tonsils:	wnl enlarged
Angle class:	I II III sub	Frenum:	wnl deep mx labial
Upper arch length:	mild mod sev crdg sp		
Lower arch length:	mild mod sev crdg sp	Path of opening:	st right left
Upper midline:	|	Path of closure:	st right left
Lower midline:	|	Range of motion:	full limited
Overbite:	%	Mm. of mastication:	wnl
Overjet:	mm	R Click/pop:	pfl nonpfl recip
Crossbites:		L Click/pop:	pfl nonpfl recip

□ Diagnostic Records Advised □ Observation _____ Months □ To Call Back □ Treatment Not Indicated

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Name _____
Birth Date_____ Age_____
Name of Physician _____

What brings you to our office today? (your main concern)_____
_____
_____

How is your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you or have you had any of the following?

- ☐ Neurological Problems
- ☐ Psychiatric Care
- ☐ Epilepsy/Seizures
- ☐ Vision Problems
- ☐ Airway Problems
- ☐ Hay Fever, Allergies
- ☐ Tonsil/Adenoid Problems
- ☐ Rheumatic Fever
- ☐ Heart Problems/Defects
- ☐ Heart Murmurs
- ☐ High/Low Blood Pressure
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Respiratory Problems
- ☐ Diabetes
- ☐ Hepatitis or Liver Disease
- ☐ Stomach Problems
- ☐ Kidney Problems
- ☐ Hormone Disorder
- ☐ Anemia
- ☐ Hemophilia
- ☐ Immunilogical Disorders
- ☐ Cancer
- ☐ HIV / AIDS
- ☐ Allergies/Medicines/Drugs
- ☐ Prosthetic joint/valve
- ☐ Osteoporosis
- ☐ Hospitalizations (describe)
  _____
- ☐ Other condition (please note)
  _____
  _____

Are you currently under medical treatment or taking any medication? ☐ Yes ☐ No
Please describe _____
Have you ever had any trauma to your head, neck, face, or mouth regions? ☐ Yes ☐ No
Please describe _____

Have you ever noticed any noises (pops, clicks, grinding) in your jaw joint area? ☐ Yes ☐ No
Have you ever had any pain in your jaw joint area? ☐ Yes ☐ No
Have you ever had an episode in which you could not open or close your jaw? ☐ Yes ☐ No

Approximate date of last dental visit _____
Approximate date when teeth were last cleaned _____
Do you have any cavities or fillings that are planned for the near future? ☐ Yes ☐ No
Have you ever been treated for periodontal (gum) pockets or disease? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?
_____

Would you like to discuss a medical problem with the doctor in private? ☐ Yes ☐ No

Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

Please note that a copy of our Notice of Privacy Practices may also be found at http://www.northsideortho.com/privacy.html