



Northside Orthodontics

Please help us serve you better by answering a few questions. All information is confidential, and is used only by the office for our files.

Christopher J. Getchell, D.D.S

Date _____

Patient Name _____

Date of Birth _____ Age _____ Sex _____

Address _____ City _____ Zip Code _____

Home Phone () _____ Business phone () _____ extension _____

Cell Phone () _____ Email address _____

Married _____ Single _____ Divorced _____ Separated _____ Widowed _____

Employed By _____

Address _____

Spouse Employed By _____

Business Phone () _____ extension _____

Person assuming financial responsibility for orthodontic treatment _____

Address (if different) _____

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

Your current Dentist _____

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

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

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	Path of opening:	st right left
Lower arch length:	mild mod sev crdg sp	Path of closure:	st right left
Upper midline:		Range of motion:	full limited
Lower midline:		Mm. of mastication:	wnl
Overbite:	%	R Click/pop:	pfl nonpfl recip
Overjet:	mm	L Click/pop:	pfl nonpfl recip
Crossbites:			

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