STEVEN R. WYNN, D.D.S., M.S.

ORTHODONTICS
FOR ADULTS AND CHILDREN

GET ACQUAINTED HISTORY

Patient's Name ______________________ Date __________ Age ______ Sex _____

Birthdate ______________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Residence Address ______________________ Phone ( ) __________
NUMBER & STREET CITY ZIP CODE

Occupation ______________________ Employer ______________________

Business Address ______________________ Cell ( ) __________
NUMBER & STREET CITY ZIP CODE

Spouse's Name ______________________ Spouse's Employer ______________________

Business Address ______________________ Cell ( ) __________
NUMBER & STREET CITY ZIP CODE

Person Financially Responsible ______________________ Responsible Person SSN# ______________________

Are you covered by insurance for orthodontic treatment? .... ❑ YES ❑ NO

Insurance Company Name ______________________

Has any member of your family been a patient here before? .... ❑ YES ❑ NO If yes, who? ______________________

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

Dentist ______________________ Oral Surgeon ______________________ Physician ______________________

Reasons for seeking orthodontic consultation ______________________

Does patient desire treatment? .... ❑ YES ❑ NO

GENERAL HEALTH: .... ❑ EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR

Have you ever had:

- Orthodontic Treatment? .... ❑ YES ❑ NO if yes, year? __________
- Oral Surgery / Extractions? .... ❑ YES ❑ NO if yes, year? __________
- Periodontal Treatment? .... ❑ YES ❑ NO if yes, year? __________

Problems of the jaw. Have you ever experienced:

- Cracking of the jaw? .... ❑ YES ❑ NO
- Pain (joint, ear, side of face)? .... ❑ YES ❑ NO
- Difficulty in opening and closing? .... ❑ YES ❑ NO
- Difficulty in chewing? .... ❑ YES ❑ NO

Habits. Do you:

- Clench or grind your teeth while awake or asleep? .... ❑ YES ❑ NO
- Mouth breathe while awake or asleep? .... ❑ YES ❑ NO
- Suck a thumb or finger? .... ❑ YES ❑ NO if no, did you in the past? ❑ YES ❑ NO
- Tongue thrust? .... ❑ YES ❑ NO

Do you have any speech problems? .... ❑ YES ❑ NO

Have you been informed of any missing or extra teeth? .... ❑ YES ❑ NO

Has an orthodontist been consulted previously? .... ❑ YES ❑ NO

Has either parent had orthodontic treatment? .... ❑ YES ❑ NO

Have you had any serious illness or condition requiring a physician's care
or hospitalization within the last five years? .... ❑ YES ❑ NO

If yes, please explain: ______________________

Have tonsils and adenoids been removed? .... ❑ YES ❑ NO if yes, year? __________

Has there been any injuries to the face, mouth or teeth? .... ❑ YES ❑ NO

If yes, please explain: ______________________

List any drugs or medications now being taken: ______________________

Are you allergic to any medication or substance? .... ❑ YES ❑ NO

If yes, please explain: ______________________

Have you ever had?

❑ Hepatitis	❑ Blood Disorders	❑ Cancer
❑ Diabetes	❑ Difficulty in breathing	❑ Epilepsy
❑ Glaucoma	❑ Heart Trouble	❑ Kidney Trouble
❑ Tumor or Growth	❑ Rheumatic Fever/ Rheumatic Heart Disease	

Women: Are you pregnant? .... ❑ YES ❑ NO

VISUAL EXAMINATION FINDINGS

I. PERSONAL COMMENTS BY PATIENT

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____

____

II. CLASSIFICATION OF MALOCCLUSION

- ❑ Cl. I
- ❑ Cl. II div.1
- ❑ Cl. II div.1 subdiv. ______________
- ❑ Cl. II div.2
- ❑ Cl. III

III. DESCRIPTIVE FINDINGS

- ❑ Anterior bite relationship is normal
- ❑ Closed bite: ❑ Moderate ❑ Severe
- ❑ Openbite is _____ mm.
- ❑ Openbite tendency
- ❑ Overjet is _____ mm.
- ❑ Midline Deviation ______________
- ❑ Crowding upper anteriors _____ mm,
- ❑ Crowding lower anteriors _____ mm.
- ❑ Missing teeth ______________
- ❑ Impacted teeth ______________
- ❑ Malformed teeth ______________
- ❑ Crossbite ______________
- ❑ Generalized Gingival Recession ______________
- ❑ Bone loss ______________
- ❑ Generalized Spacing ______________
- ❑ Fractured Incisal Edge ______________
- ❑ Diastema ______________
- ❑ Deep Curve of Spee
- ❑ Possible tooth size discrepancy ______________

IV. PROFILE

- ❑ Convex
- ❑ Straight
- ❑ Concave

V. HABITS

- ❑ Tongue Thrust
- ❑ Thumb Sucking ❑ Past ❑ Present
- ❑ Mouth Breathing
- ❑ Finger Sucking
- ❑ Lip Sucking
- ❑ Max Labial Frenum
- ❑ Enlarged tonsils or adenoids
- ❑ Bruxism
- ❑ Ankyloglossia
- ❑ Other ______________

VI. TMJ FUNCTION

- ❑ Normal
- ❑ Crepitus ❑ r ❑ l
- ❑ Limited movement
- ❑ Clicking/Popping ❑ r ❑ l
- ❑ Pain ❑ r ❑ l
- ❑ Locking ❑ r ❑ l
- ❑ History ______________

VII. SPEECH

- ❑ Normal
- ❑ Affected by Malocclusion
- ❑ Affected by Tongue Function

VIII. HYGIENE

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

IX. ADDITIONAL FINDINGS

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- ❑ I.I. ______________
- ❑ Beg. Ortho. Survey (less ______________)
- ❑ Beg. Consult
- ❑ Recall _____ month
- ❑ Head Film only
- ❑ FMX only (less ______________)
- ❑ Mini FMX only (less ______________)
- ❑ Lateral Jaws only

PATIENTS PLEASE NOTE:

INITIAL EXAMINATION	N/C
IMPRESSIONS & ORTHODONTIC MODELS	$50
DIAGNOSIS PLAN OF TREATMENT & CONSULTATION APPOINTMENT	$75
TOTAL	$125

(THESE FEES ARE DUE AT THE TIME SERVICES ARE RENDERED AND ARE APPLICABLE TOWARD THE TOTAL ORTHODONTIC FEE IF TREATMENT IS STARTED WITHIN ONE YEAR.)