



Bel Air Office
 4A North Avenue, Suite 208
 Bel Air, MD 21014
 (410) 879-1180

White Marsh Office
 8114 Sandpiper Circle, Suite 207
 White Marsh, MD 21236
 (410) 931-3350

Glen Burnie Office
 804 Landmark Drive, Suite 126
 Glen Burnie, MD 21061
 (410) 761-9180

www.GreatSmileForYou.com

Patient Information

Date _____ M / F

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Birthdate _____ Home Phone _____ Work Phone _____

If patient is a minor, give parent's or guardian's name _____ Email _____

Has any family member been treated or is in treatment at our office? _____
Name Relationship

General Dentist _____
Name Address Phone

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

Responsible Party Information

Name _____
Last First Middle Marital Status

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Relationship to Patient _____ Birthdate _____ Social Security # _____

Employer _____ Occupation _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Policy Holder's Name _____ Policy ID _____

Insurance Company _____ Group No. _____ Policy Holder's Birthdate _____

Insurance Co. Address _____

I hereby instruct and direct my Insurance Company to pay the dental expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered directly to Cramer and Noorani. Insurance benefits are not a guarantee of payment.

Patient copays are an estimate and I am responsible for any unpaid balance.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature of Policyholder _____ **Date** _____

Notice of Privacy Practices

I have read and understand the office Notice of Privacy Practices, and I am aware that a copy of the policy is available upon request.

Signature _____ **Date** _____

Medical History

Physician Name _____ Phone _____

Address _____

Date of last completed Physical _____ Results _____

Is patient receiving any medication? Y N If yes, list names and purpose: _____

Has patient ever been hospitalized? Y N If yes, Why _____

Have you had any history of or difficulty with any of the following? Please circle Yes or No

Y N A.I.D.S./H.I.V.	Y N Cerebral Palsy	Y N Allergic Rhinitis	Y N Learning Disability
Y N Anemia	Y N Cleft Lip/Palate	Y N Hearing Problems	Y N Prosthetic Implant
Y N Asthma	Y N Convulsions or Seizures	Y N Heart Problems	Y N High Blood Pressure
Y N Bladder Problems	Y N Developmental Disability	Y N Heart Murmur	Y N Rheumatic Fever
Y N Blood Transfusion	Y N Hepatitis or Jaundice	Y N GERD	Y N Sinus Problems
Y N Bruise Easily	Y N Epilepsy or Fainting	Y N Kidney Disease	Y N Thyroid Disease
Y N Cancer	Y N Anxiety or Depression	Y N Liver Disease	Y N Tuberculosis
Y N Diabetes	Y N Bleeding Disorder	Y N Tobacco Use	Y N Growth Disorder
Y N Osteoporosis (if yes what medications)		Y N Any injury to teeth and/or jaws	

If pregnant, what month _____

Are you allergic to, or ever had adverse reaction to the following? If Yes, Please circle

Aspirin Amoxicillin Metal Latex Local Anesthetic Sedatives Any Others _____

Initial _____ Date _____

For Doctor's Use

Dental Examination

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 O = Not erupted X = Missing Im = Impacted
Right e d c b a a b c d e *Left* S = Supernumerary C = Cong. missing
e d c b a a b c d e I = Implant
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Facial Profile: Straight Prognathic Retrognathic Concave Convex
Lip Posture: Relax Strain Incompt. Redundant
Incision-Stomion: ___mm Gingival Display on Smile: N Y ___mm
Midline: Max. to Facial (mm) R _____ L Mand. to Max. (mm) R _____ L

Molar Relationship: Class I II III
Canine Relationship: Class I II III
Overbite: ___% Overjet: ___mm Openbite: ___mm Ant. Lateral Post.
Crowding: Severe Excessive Slight
Spacing: Severe Excessive Slight
Crossbite: _____ Gingival Stripping: _____

TMJ maximum opening ___mm Excursive limits Y / N Pain Y / N Sounds Y / N

Oral Tissue: _____

Perio Exam: _____

Habits: Finger Thumb Tongue Lip Bruxism Nail Biting

Caries Index: _____ Speech: _____ Oral Hygiene: _____

Chief Complaint: _____

Case Disposition: Treat now Recall No Treatment

Comments: _____