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*Practice Limited To Orthodontics*



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[www.greatsmileforyou.com](http://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 \_\_\_\_\_ E-mail \_\_\_\_\_

Any member of your family has been or is in treatment at our office? \_\_\_\_\_  
Name Relation

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 that my Insurance Company is to pay directly to: Cramer & Noorani, 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. 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 _____			
<b>Have you had any history of or difficulty with any of the following? Please circle Yes or No</b>			
Y N A.I.D.S/H.I.V.	Y N Cerebral Palsy	Y N Hay Fever	Y N Mental Retardation
Y N Anemia	Y N Cleft Lip/Palate	Y N Hearing Problems	Y N Prosthetic implant
Y N Asthma	Y N Convulsions	Y N Heart Problems	Y N Heart Murmur
Y N Bladder Problems	Y N Developmental Disability	Y N Hepatitis	Y N Rheumatic Fever
Y N Blood Transfusion	Y N Diabetes	Y N Jaundice	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 Tuberculosis	Y N Liver Disease	Y N Growth Disorder
Y N Osteoporosis (If yes what medications)		Y N Bleeding Disorder	Y N Nervous Disorder
Y N GERD		Y N Any injury to teeth and/or jaws	
<b>Are you allergic to, or ever had adverse reaction to the following? If Yes, Please circle</b>			
Aspirin	Amoxicillin	Metal	Latex
Local Anesthetic	Sedatives	Any Others _____	
If pregnant, what month _____		Initial _____ Date _____	

### For Doctor's Use

## Dental Examination

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">8 7 6 5 4 3 2 1</td> <td style="text-align: center;">1 2 3 4 5 6 7 8</td> </tr> <tr> <td style="text-align: center;"><i>Right</i>      e d c b a</td> <td style="text-align: center;"><i>Left</i>      a b c d e</td> </tr> <tr> <td style="text-align: center;">e d c b a</td> <td style="text-align: center;">a b c d e</td> </tr> <tr> <td style="text-align: center;">8 7 6 5 4 3 2 1</td> <td style="text-align: center;">1 2 3 4 5 6 7 8</td> </tr> </table>	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	<i>Right</i> e d c b a	<i>Left</i> a b c d e	e d c b a	a b c d e	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	<p>O = Not erupted      X = Missing    Im = Impacted  S = Supernumerary    C = Cong. missing  I = Implant</p>
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8								
<i>Right</i> e d c b a	<i>Left</i> a b c d e								
e d c b a	a b c d e								
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8								
Facial Profile: Orthognathic    Prognathic    Retrognathic    Concave    Convex									
Lip Posture: Relax              Strain              Incompt.      Redundant									
Incision-Stomion: _____mm	Gingival Display on Smile: N      Y _____mm								
Midline: <u>Max. to Facial (mm)</u> R _____   _____ L	<u>Mand. to Max. (mm)</u> R _____   _____ L								
Molar Relationship: <u>Class</u> I      II      III      End to End									
Canine Relationship: <u>Class</u> I      II      III									
Overbite: _____%              Overjet: _____mm	Openbite: _____mm    Ant.    Lateral    Post.								
Crowding:              Severe              Excessive      Slight									
Spacing:              Severe              Excessive      Slight									
Crossbite: <i>Right</i> _____   _____ <i>Left</i>	Gingival Stripping: <i>Right</i> _____   _____ <i>Left</i>								
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: _____									