



Jeffrey F. Cramer, DDS

Michael Noorani, MS, DDS

Practice Limited To Orthodontics



Bel Air

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

Glen Burnie

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

White Marsh

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

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 _____

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 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 Any injury to teeth and/or jaws	
Y N GERD			

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 _____

If pregnant, what month _____ Initial _____ Date _____

For Doctor's Use

Dental Examination

<p style="text-align: center;">8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8</p> <p>Right e d c b a a b c d e Left</p> <p style="text-align: center;">e d c b a a b c d e</p> <p style="text-align: center;">8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8</p>	<p>O = Not erupted X = Missing Im = Impacted</p> <p>S = Supernumerary C = Cong. missing</p> <p>I = Implant</p>
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Facial Profile: Orthognathic 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 End to End

Canine Relationship: Class I II III

Overbite: _____% Overjet: _____mm Openbite: _____mm Ant. Lateral Post.

Crowding: Severe Excessive Slight

Spacing: Severe Excessive Slight

Crossbite: Right _____ | _____ Left Gingival Stripping: Right _____ | _____ Left

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: _____