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 Noorani Orthodontics. 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:____