EXAMINATION CARD

Date of Examination__________ Date of Birth __________

Patient s Name__________ (Last) (First) (MI) Age _____ Sex _____ School__________

Patient s Mailing Address __________ (City) (State) (Zip)

Father s / Stepfather s Name __________ Father s Home Phone__________

Father s Address__________ Father s Cell Phone__________

Father s Social Security #__________ Father s Date of Birth__________

Father s Work Phone __________ Occupation __________ Employed By__________

Mother s / Stepmother s Name__________ Mother s Home Phone__________

Mother s Address__________ Mother s Cell Phone__________

Mother s Social Security # __________ Mother s Date of Birth__________

Mother s Work Phone __________ Occupation __________ Employed By__________

Person Financially Responsible __________ Relationship to Patient __________

Billing Address__________ (Street) (City) (State) (Zip)

Nearest Relative__________ Relationship__________ Phone__________

If you have orthodontic insurance/Name of Insured __________

Insurance Company__________ Name of Employer Carrying Insurance __________

Employee s Name__________ Social Security #__________ DOB __________

Please list any family member(s) seen by Dr. Carlton.__________

Whom may we thank for referring you? __________

MEDICAL HISTORY

Email__________

Patient s Physician__________

Have tonsils and adenoids been removed? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No

Check any of the following for which the patient has been treated:

❑ Diabetes	❑ Tuberculosis	❑ Endocrine Problem	❑ Pneumonia
❑ Anemia	❑ Prolonged Bleeding	❑ Heart Trouble	❑ Epilepsy
❑ Fainting or Dizziness	❑ Rheumatic Fever	❑ Bone Disorder	❑ Kidney Disorder
❑ Asthma	❑ Anxiety Disorder	❑ Liver Disorder	❑ HIV/AIDS
❑ Heart Disease	❑ Lung Disease	❑ Hepatitis	

List any other serious illness and operations not mentioned above. __________

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List any allergies or drug sensitivities. __________

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Please complete Dental History on back.

DENTAL HISTORY

What is your main concern? ______________________________

Patient s Dentist ______________________________

Have there been any injuries to the face, mouth or teeth? ❑ Yes ❑ No

Has the patient ever sucked a thumb or finger? ❑ Yes ❑ No

Has the patient had speech therapy? ❑ Yes ❑ No

Is the patient a mouthbreather? While Awake? ❑ Yes ❑ No While Asleep? ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Does the patient s face and teeth resemble Mother? ❑ Yes ❑ No Father? ❑ Yes ❑ No

Or is this child adopted? ❑ Yes ❑ No

OFFICE USE ONLY

1. Facial Pattern ______________________________
2. Habits ______________________________
3. Lip Tone ______________________________
4. Classification ______________________________
5. Crowding ______________________________
6. Overbite ______________________________
7. Overjet ______________________________
8. Additional Observations ______________________________

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9. Suggestions and Possible Treatment ______________________________

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10. Fee ______________________________
11. Parent Reaction ______________________________
12. Patient Reaction ______________________________
13. TMJ Findings ______________________________
14. Additional Remarks ______________________________

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