Northside Orthodontics

Christopher J. Getchell, D.D.S

Date ________________

Patient Name ____

Date of Birth _______________________ Age ______________ Sex ____________

Address ____________________________________ City _______________________Zip Code ________________

Home Phone ____________________ Business phone ___________________

Cell Phone ____________________ Email address ____

Married Single Divorced Separated Widowed

Employed By ____

Address ____

Spouse Employed By ____

Business Phone _______________

Person assuming financial responsibility for orthodontic treatment ___________________________________

Address (if different) ____

Who may we thank for referring you to our office? ____

Your current Dentist ____

Patient's attitude toward Orthodontic Treatment? Favorable Indifferent Negative

Has patient received previous orthodontic treatment or consultation? Yes No When? ______

Do You Have Orthodontic Insurance? Yes No Insurance Policy ____

Name of Insured (if different) ____

Social Security Number of Insured _____________________ Date of Birth of Policy Holder___________________

For Doctor's Use

Profile:	st concave convex	Hygiene:	good fair poor
Lip muscle tone:	wnl hyper hypo	Gingiva:	wnl
Smile line:	coincident non	Habits:	none th tg brux
Incisal length:	mm	Tonsils:	wnl enlarged
Angle class:	I II III sub	Frenum:	wnl deep mx labial
Upper arch length:	mild mod sev crdg sp		
Lower arch length:	mild mod sev crdg sp	Path of opening:	st right left
Upper midline:	|	Path of closure:	st right left
Lower midline:	|	Range of motion:	full limited
Overbite:	%	Mm. of mastication:	wnl
Overjet:	mm	R Click/pop:	pfl nonpfl recip
Crossbites:		L Click/pop:	pfl nonpfl recip

☐ Diagnostic Records Advised ☐ Observation _____ Months ☐ To Call Back ☐ Treatment Not Indicated

Northside Orthodontics

Christopher J. Getchell, D.D.S.

Name ____
Birth Date ____________________ Age ______________
Name of Physician ______________________________________

What brings you to our office today? (your main concern)______________________________
____
____

How is your general health? Excellent Good Fair Poor

Do you or have you had any of the following?

- Neurological Problems
- Psychiatric Care
- Epilepsy/Seizures
- Vision Problems
- Airway Problems
- Hay Fever, Allergies
- Tonsil/Adenoid Problems
- Rheumatic Fever
- Heart Problems/Defects
- Heart Murmurs
- High/Low Blood Pressure
- Thyroid Problems
- Asthma
- Tuberculosis
- Respiratory Problems
- Diabetes
- Hepatitis or Liver Disease
- Stomach Problems
- Kidney Problems
- Hormone Disorder
- Anemia
- Hemophilia
- Immunilogical Disorders
- Cancer
- HIV / AIDS
- Allergies/Medicines/Drugs
- Prosthetic joint/valve
- Osteoporosis
- Hospitalizations (describe)

  ____

- Other condition (please note)

  ____

  ____

Are you currently under medical treatment or taking any medication? Yes No
Please describe ____
Have you ever had any trauma to your head, neck, face, or mouth regions? Yes No
Please describe ____

Have you ever noticed any noises (pops, clicks, grinding) in your jaw joint area? Yes No
Have you ever had any pain in your jaw joint area? Yes No
Have you ever had an episode in which you could not open or close your jaw? Yes No

Approximate date of last dental visit ______________________________
Approximate date when teeth were last cleaned ______________________________
Do you have any cavities or fillings that are planned for the near future? Yes No
Have you ever been treated for periodontal (gum) pockets or disease? Yes No

Are you pregnant? Yes No N/A

Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?
____

Would you like to discuss a medical problem with the doctor in private? Yes No

Signature ______________________________ Date ____________________

Christopher J. Getchell, D.D.S.

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

____

____

Please note that a copy of our Notice of Privacy Practices may also be found at http://www.northsideortho.com/privacy.html