JANZEN, JANZEN & CHWA, ORTHODONTICS, LTD.
1220 Meadow Road
Northbrook , Illinois 60062

Home Phone # ___________________________

Patient's Name ____ ____________________________
(Last) (First) (Nickname)

Birth Date _____________________ Age ________________ Male ____________ Female____________

Home Address ______________________________________ City ________________________ Zip Code ____________

Father's Name _____________________________ Occupation ___________________ Bus. Ph. # __________________

Mother's Name ____________________________ Occupation ___________________ Bus. Ph. # __________________

Billing Name and Address (If Different From Above)

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____ Phone #___________________________

Family Dentist _________________________________ Address ____

By Whom Were You Referred To Our Office ? ____

Family Members in Treatment (Past or Present) ____

Orthodontic Insurance ? ______ Yes ______ No Name and Address of Insurance Company: ______________________

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	Yes	No
Is the patient in good health?	________	________
Is the patient under the care of a physician?	________	________
Presently taking medication?	________	________
Does the patient have any history of:		
Frequent colds?	________	________
Allergies (Aspirin, Penicillin)?	________	________
Dizziness or fainting?	________	________
Unfavorable reaction to dental care?	________	________
Previous orthodontic treatment?	________	________
Injury to teeth?	________	________
TMJ / TMD symptoms?	________	________
Heart trouble, diabetes, asthma, tuberculosis, Kidney or liver disease or any other disorder?	________	________
If so please outline:		

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Have tonsils and adenoids been removed ?	________	________
Is the patient cooperative at home ?	________	________

Please check any habit(s) the patient have:

________ Grinding of Teeth ________ Mouth Breathing ________ Finger / Thumb Sucking
________ Lip Biting ________ Tongue Biting ________ Nail Biting

Additional Comments: ____

Date: _______________________________ Parent's Signature: ____

Name …………………………………………………………………………….. Date ………………………………

Angle Class: Molar R ………..……..….. Molar L ………………..... Cuspid R ………..…..... Cuspid L ……...……...…..

					E	D	C	B	A	A	B	C	D	E				
R	8	7	6	5	4	3	2	1	‖	1	2	3	4	5	6	7	8	**L**
	8	7	6	5	4	3	2	1	‖	1	2	3	4	5	6	7	8	
					E	D	C	B	A	A	B	C	D	E				

Teeth Present or Missing / Extracted

.

Overbite ……....…… Overjet ……..….…… Lower incisors impinging……...……… Openbite …….………………….………

Arch Form: Maxillary …………………..…………..…………….. Mandibular ……………..………………………………..

Arch Length: Maxillary …………………..…………..…………….. Mandibular ……………..………………………………..

Midline: Upper shift to Left / Right …..…………..…………….. Lower shift to Left / Right ………………………………..

Crossbite ……………………….……………………………..… Functional Shift ………..………

Central Diastema …………………………………..……………. Frenum ……………………………….…...……………

Congenitally Missing Teeth …………………………………………………………………………………………..

Attrition …………………........………...……….....………… Abrasion ……………………………………………………………

Profile ……………….…..……………. Smile ………..………………...……… Oral Hygiene ……………………………………

Habits …………………………………………………..……………………….. Mouthbreathing ………………….……………..

TMJ Symptoms ………………………………………………………………………………………………………..

Remarks and Treatment Suggestions:

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Time Estimate: ……………………………………………….

Fee Total ………………………………. Initial Payment ………………………………. Monthly …………………………..