Carlton A. Shiraki, D.D.S., A Professional Corporation

Diplomate, American Board of Orthodontics

ACQUAINTANCE CARD

ID. _____
Date of Exam: ___/___/___
Date of Birth: ___/___/___

Patient's Name: (Last) _____ (First) _____ M.I. ____ Age: _____ Sex: M / F
Address _____ City _____ Zip _____ Home Ph: _____
Best Contact: _____ Email Contact: _____ Patient's Cell: _____
Dentist's Name: _____ Address: _____ Ph: _____ Referred by: _____

PART A - MINOR PATIENTS (UNDER AGE 18)

School: _____ Grade: _____ Nickname _____
MOTHER _____ DOB ___/___/___ Marital Status: M / D / S
Address _____ City _____ Zip _____ Home Ph: _____
Employer: _____ Position: _____ Wk Ph: _____ Cell Ph: _____
FATHER _____ DOB ___/___/___ Marital Status: M / D / S
Address _____ City _____ Zip _____ Home Ph: _____
Employer: _____ Position: _____ Wk Ph: _____ Cell Ph: _____
Names and ages of other children in family: _____

PART B - ADULT PATIENTS

Employer: _____ Position: _____ Wk Ph: _____ SS # ____/____/____
Spouse/Partner: _____ DOB ____/____/____ Cell Ph: _____
Employer: _____ Position: _____ Wk Ph: _____ Other: _____

PART C - FINANCIAL INFORMATION

RESPONSIBLE PARTY: _____ Contact Nos.: _____
Address: _____ SS # ____/____/____ DOB: ____/____/____
RELATIVE NOT LIVING WITH YOU: _____ Relationship: _____
Address: _____ Contact Nos.: _____

PART D - MEDICAL HISTORY

Is patient in good health? ☐ Yes ☐ No Patient's Physician _____ Ph: _____
Is patient under care of physician? ☐ No ☐ Yes If yes, since when and why? _____
Does patient have any history of a major illness? (Check those that apply)

☐ Rheumatic Fever	☐ Anemia	☐ Hepatitis	☐ Diabetes	☐ Heart Disease	☐ Bone Disorders
☐ Prolonged Bleeding	☐ Epilepsy	☐ AIDS	☐ Pneumonia	☐ Nervous Disorders	☐ Liver Disorders
☐ Fainting & Dizziness	☐ Cancer	☐ Asthma	☐ Kidney Disease	☐ Endocrine Problems	☐ _____

Is there any disease, condition, or problem not listed above or anything else we should know about your health that we have not covered in this form? _____
Does patient have tendency to: ☐ Colds ☐ Sore throats ☐ Ear infections
Have tonsils and adenoids been removed? ☐ No ☐ Yes If yes, at what age? _____
List any drugs or medications now being taken. Give Reasons _____
List any allergies or drug sensitivities: _____
**(Minors Only) Height _____ Weight _____ Has the patient reached puberty? ☐ Yes ☐ No*
Girls - Has started menstruation? ☐ Yes ☐ No; Boys - Has voiced changed? ☐ Yes ☐ No

PART E - DENTAL HISTORY

Approximate date of last dental exam: ___/___/___ Were x-rays taken? ☐ Yes _____ No ☐
Have there been any injuries to the face, mouth or teeth? ☐ Yes _____ No ☐
Has the patient ever sucked a thumb or fingers? ☐ Yes If so, until what age? _____ No ☐
Does the patient have any speech problems? ☐ Yes _____ No ☐
Is the patient a mouth breather? ☐ Yes If so, while awake? ☐ while asleep? ☐ _____ No ☐
Has patient been informed of any missing or extra permanent teeth? ☐ Yes If yes, please describe _____ No ☐
Has an orthodontist been consulted previously? ☐ Yes _____ No ☐
Has either parent had orthodontic treatment? ☐ Yes If so, any teeth extracted? _____ No ☐
List any musical instruments played _____
Reason for consultation: _____

PART F - INSURANCE INFORMATION

Primary Subscriber: _____ ID # _____ DOB _____
Insurance Carrier Name: _____ Group # _____ Ph No. _____
Coverage: $ _____ _____ % Age Limit? _____ Wait Per.? _____ Note: _____
Secondary Subscriber: _____ ID # _____ DOB _____
Insurance Carrier Name: _____ Group # _____ Ph No. _____
Coverage: $ _____ _____ % Age Limit? _____ Wait Per.? _____ Note: _____
Additional Subscriber: _____ ID # _____ DOB _____
Insurance Carrier Name: _____ Group # _____ Ph No. _____
Coverage: $ _____ _____ % Age Limit? _____ Wait Per.? _____ Note: _____

PART G - FLEX PLAN/MEDICAL SAVINGS INFORMATION

Do you have a flexible spending account? ☐ No ☐ Yes If so, flex plan year start date: Mo. ____ Yr. ____ Amount? _____

I certify that the above information is complete and accurate.

x _____
Patient's Signature (or parent if patient is a minor)

Member American Association of Orthodontists

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Name: (Last) _____ (First) _____ (Nickname) _____

1. Angle Classification and Relation of Segments

	RIGHT SIDE		LEFT SIDE	
	MOLAR	CUSPID	MOLAR	CUSPID
CLASS I				
CLASS II				
DIV II				
CLASS III				

2. Dentition

R				E	D	C	B	A	A	B	C	D	E				L
I	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	E
G	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	F
H				E	D	C	B	A	A	B	C	D	E				T
T																	

O – ERUPTED TEETH
X – EXTRACTED
S – SUPERNUMERARY
M – CONGENITALLY MISSING
☐ – ATYPICAL FORM
I – IMPACTION
D – DECALCIFICATION

3. Arch Length: Max. Excess ☐ Adequate ☐ Deficient ☐ Amt. _____ MM
Mand. Excess ☐ Adequate ☐ Deficient ☐ Amt. _____ MM

4. 321 / 321 Crowded ☐ Even ☐ Spaced ☐ Amt. _____ MM
321 / 321 Crowded ☐ Even ☐ Spaced ☐ Amt. _____ MM

5. Crossbite: No ☐ Right ☐ Left ☐ Max. Buccal ☐ Max. Lingual ☐ Anterior ☐ _____
6. Overbite: Normal ☐ Open Bite ☐ Closed Bite ☐ _____ % ☐ _____
7. Overjet: Crossbite ☐ End to End ☐ Normal ☐ Excessive ☐ Amt. _____
8. Curve of Spee: Deep ☐ Normal ☐ Flat ☐ Reversed ☐
9. Mid-Line: Max. _____ Normal ☐ Mand. _____ Occlusion _____
10. Path of Closure: Unrestrictive ☐ Restrictive ☐ Contact and Mesially ☐ Pseudo Class III ☐ Contact and Distally ☐
11. TMJ? No ☐ Clicks? R ☐ L ☐ PAIN ☐ Restrictive Movement ☐ Max. Opening _____ MM Deviation R L _____ MM

12. Lip Posture: Together ☐ Strained ☐ Apart ☐
13. Lip Muscle tone: Hypo ☐ Normal ☐ Hyper ☐
14. Abnormal Frenum: None ☐ Upper ☐ Lower ☐
15. Deficient Gingival Attachment No ☐ _____
16. Tonsils and Adenoids: Normal ☐ None ☐ Large and a Problem ☐
17. Eruption Pattern: Early ☐ Normal ☐ Late ☐
18. Profile: Satisfactory ☐ Flat ☐ Protrusive ☐ Double Protrusive ☐ Max/Mand Retrusive ☐ Max/Mand Protrusive ☐
19. Smile: R S P
20. Habits: No ☐ Tongue Thrust ☐ Frontal ☐ Lateral ☐ Lip Biting ☐ Finger or Thumbsucking ☐ Mouth Breathing ☐
21. Oral Hygiene: Good ☐ Fair ☐ Poor ☐

Exam Summary: ***Est. Fee*** _____ ***Tx Time:*** _____ ***Mos.***

Status: ☐ Ready for Treatment ☐ Pat. WCB ☐ Recall: ☐ 6 Mos. ☐ 1 Yr. ☐ Other _____
☐ No Further Appointments Needed

POR: ☐ Now ☐ None ☐ After patient decides on treatment

Special Arrangements: _____

Current X-Rays Last Checkup: _____

Panoramic: _____/_____/_____; Ant. PAs _____/_____/_____; BWS _____/_____/_____

Records Needed

☐ Study Models
☐ #1 Less Bitewings (Complete: #4, 7, 9, & 10) Dup Px ? _____
☐ #2 (#9 Ceph & 10 Photos)
☐ #4 Panoramic/Full Mouth
☐ #7 Anterior PAs
☐ #9 Ceph ☐ Lateral ☐ AP
☐ #10 Photos & Slides
☐ _____

Date	Initial Notes/Findings	Recall	Chg.

Date											
Initials											