Welcome! to

NEW PATIENT EVALUATION

1) PATIENT INFORMATION

Last:________________________, First:________________________, MI:____ I prefer to be called:______________
Street____________________________________ City__________________________________ Zip_____________
Birth Date ______/______/______, Age:______ Sex: ☐ Male ☐ Female; School________________________
Email address ____@_______________________● __________
Home # (______)-______-_________ Cell #(______)-______-________ Work #(______)-______-________
Preferred method of contact: ☐ email; ☐phone (home, cell, work?); ☐ text msg; ☐ postal mail
How did you hear about this office?____
Emergency contact name:_________________________Relationship: ____________Phone #(______)-_____-______
Parents' Names (if child): Mother __________________________ Father: ____________________________

2) FINANCIAL INFORMATION

Person financially responsible for this account: ☐ Self ☐ Parent; ☐ Other Party; Name:______________________
Billing address if different from custodial parent:
Street______________________________City____________________Zip________
Dental insurance? ☐Yes ☐No; Covers Orthodontic Treatment? ☐Yes ☐No
Primary Policy Holder: Last:______________________________, First_________________________________, MI:___
Employer:__________________________________Years with Employer:___; Spouse Name ___________________
Employer's Address: Street__________________________________ City_______________________ Zip___________
Dental Insurance Company:________________________, Group #________________, Policy#_________________
SSN_____-_____-_________ (for insurance verification) Policy Holder DOB ______/_______/19___
Secondary Insurance? ☐Yes ☐No; Details____
Do you participate in a flex savings plan? ☐Yes ☐No

3) PROFESSIONAL INFORMATION

General dentist's name___________________________________ Seen by dentist regularly?__________
Is this a transfer from another orthodontist?_ ☐Yes ☐No Records being sent or available? ☐Yes ☐No
Orthodontist name_____________________________, City_______________ State______ Phone#_____________

Any allergies or chronic health problems?____
What is your primary orthodontic concern?____

4) ORTHODONTIC TREATMENT NEEDS DATE _____/____/201___

Dentition Stage: Early - Mixed – Late - Adult Growth phase: □pre □peak □post □complete

Missing Teeth or Imp	R		L	Overjet	WNL	Excess __ mm	Under __mm	
				L Molar: I, E, II, III		R Molar: I, E, II, III	Skeletal: I, II, III	
Crossbites	R		L	Crowding	Max	WNL	Space	Crowding ≤3 6 9
					Man	WNL	Space	Crowding ≤3 6 9
Vert Bite	%deep	mm open	Dental	Skeletal				

Notes:____
____
Probable Treatment Plan:____
Appoint for: □ Phase 1 Records □ Comprehensive Records □ Recall Mo _____Yr 201_
Est Mos Tx: _____ □ Phase 1; □Phase 2; □Limited; □Aligners

Mark J. Bentele, DDS, MS

D:\Input\46.102.52.224\Bentele_-_New_Patient_Eval_2015_10_22_22_14_27_892.DOC