INTERNATIONAL ASSOCIATION FOR ORTHODONTICS

WOODLAND FAMILY DENTAL

Phase 1

Diagnostic Treatment Chart

Patient Information

First Name	Last Name		Street/Mailing Address	City/State/Zip
Date of Birth	Age	Sex M/F	Home Phone	Cell Phone
Family Dentist		Family Physician	Other Healthcare Providers	Referred By

Person Responsible for Account

First Name	Last Name	Relationship	Address (If Different from above)	City/State/Zip
Date of Birth	Employer	Work Phone	Home Phone	Cell Phone

Dental Insurance

Insurance Company	Employer	Orthodontic Coverage (Y/N)	Name of Policy Holder	Date of Birth
Group Number	ID Number			
Secondary Insurance Company	Employer	Orthodontic Coverage (Y/N)	Name of Policy Holder	Date of Birth
Group Number	ID Number			

Initial Records Checklist

	DATE		DATE
Medical History		Clinical Exam	
Initial Consult/Paperwork		Final Consult	
In Attendance		In Attendance	
Diagnostic Photographs		Panoramic Film	
Study Models		Cephalometric	
Informed Consent		Full Mouth Series	

Reason for Visit

(Answer Y/N)

Crowding		Habits	
Overbite		Thumbsucking	
Don't Like My Smile		Tongue Habit	
Appearance		Mouth Breathing	
Better Function		Any Other Reason:	
Airway Assessment		(Please Specify)	
My Dentist found the problem			
I/We don't see a problem			

Continued Medical History

Phase I Orthodontics

(Answer Y/N)

Tonsils or Adenoids Removed?	_____	What Age?	_____
Tendency for Colds?	_____		
Sore Throats?	_____		
Ear Infections?	_____		
Ear Tubes Placed?	_____	What Age?	_____

Dental History

(Answer Y/N)

Has patient ever sucked thumb/finger?	_____	Until What Age?	_____
Does the patient have speech problems?	_____		
Is the patient a mouth breather?	_____	Day/Night?	_____
Has either parent had orthodontic work?	_____		
Does the patient play musical instruments?	_____		
Have you consulted an orthodontist?	_____	Other Provider?	_____

Summary of Clinical Findings (To Be Completed By Dentist)

Ceph Airway Measurements	Area of Adenoids_____mm	Area of Tonsils	_____mm
Need Referral to ENT?	_____		
Overbite _____mm	Overjet _____mm	Max Opening	_____mm
Left Lateral _____mm	Right Lateral _____mm	Protrusive	_____mm
Molar Relationship	Right 1 2 3	Left	1 2 3
Cuspid Relationship	Right 1 2 3	Left	1 2 3

Profile - Soft Tissue S-Line	Upper _____mm	Lower _____mm	Convex/Concave
Maxilla	Prognathic	Straight	Retrognathic
Mandible	Prognathic	Straight	Retrognathic
Dentally	Open	Average	Closed
Skeletally	Open	Average	Closed
Growth Tendency	Vertical	Horizontal	

Arch Analysis

(Circle One)

Constricted Arch	MX	MD			
Expanded Arch	MX	MD			
Asymmetric Arch	MX	MD			
Crowding Mx	None	Spaces	Slight	Moderate	Severe
Crowding Md	None	Spaces	Slight	Moderate	Severe
Curve of Spee			Slight	Moderate	Severe
Rotations	MX Anterior	MX Posterior			
	MD Anterior	MD Posterior			

Pre-Orthodontic Periodontal Assessment

Bone Quality on Radiographs	Normal	Mild	Moderate	Severe	
Gingiva	Normal	Rolled Margins	Bleeding	Blunted Papilla	Puffy Papilla
Gingivitis	Localized	Generalized	Acute	Chronic	
Plaque	Light	Moderate	Heavy		
Calculus	Light	Moderate	Heavy		
Complicating Factors	Recession	Frenum Pull	Periodontal Involvement	Abcess/Mobility	

Date of Last Cleaning	_____	Frequency of Cleanings	_____
Pre-Treatment Brushing	_____x/day	Frequency of Flossing	_____x/week