Robert E. Rutrick, D.M.D., M.Sc.D.
ORTHODONTICS • DENTOFACIAL ORTHOPEDICS • TMJ DISORDER MANAGEMENT
Diplomate, American Board of Orthodontics

Date__________ NP#__________

Date of birth__________ SM#__________

Patient Name:______________________________
First Middle Last

Nickname __________ Age ______M/F________

Street Address______________________________

SS#______________ Height ______Weight _____

City/State/Zip______________________________

Home Phone & Area Code (____)______________

Referred by______________________________

Dentist's Name______________________________

Parent/Guardian(s)______________________________

School Attended______________________________

Father Employed By______________________________

Mother Employed By ______________________________

Bus. Address______________________________

Bus. Address______________________________

Bus. Phone (____)______________________________

Bus. Phone (____)______________________________

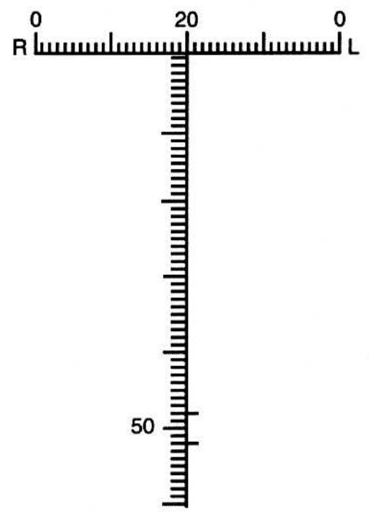
Insurance Carrier ______________________________

Insurance Carrier ______________________________

Policy #______________________________

Policy #______________________________

Emergency Contact Person: ______________________________ Phone (____)______________



Date

____

PRELIMINARY EXAM

____

____

____

PRELIMINARY DIAGNOSIS ______________________________

____

____

____

____

❑ POLAROID ______________

❑ MUSCLE PALPATION ______________

❑ ROM ______________

❑ TMJ QUEST/EXT HIST______________

❑ TMJ/HIST REVIEWED ______________

MODELS ________ MRI ______________

PHOTOS _______ MOUNT ______________

PANOREX ______ T/L SIGNED______________

CEPH __________ INF CONSENT__________

FRONTAL______ PHOTO REL __________

SMV _______ REF THANKS __________

TOMOS_______ DIAG LTR TO DR__________

ADDITIONAL REQ. REFERRALS ______________ ______________ ______________

LETTERS OF INTRODUCTION ______________ ______________ ______________

DIAG REC FEE ______________

TRMT FEE ______________ TRMT PERIOD ______________ INCLUDES__________

DOWN PYMT ____________ MO PAYMENT ______________ FIRST MO. PMT. BEGINS ____________ APPROX. _______ YRS. OF TMT.

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MEDICAL/DENTAL HISTORY:

Age: ________yrs. ________mos. Height __________ Weight __________ Date of Birth ______________________

General Health: ❑ excellent ❑ good ❑ fair ❑ poor

Any serious illness or condition? (explain) ____

Any allergies? *(please list)* ____

Any drug sensitivities: ❑ antibiotics *(specify)* ____________ ❑ pain pills (codeine, etc.) ❑ other *(specify)* ___________

Current medications being taken:

❑ vitamins ❑ pain pills ❑ muscle relaxant ❑ sleeping pills ❑ insulin ❑ birth control pills ❑ other *(specify)* _________

Does patient have or has patient ever had: *(please check)*

❑ colds ❑ cold sores ❑ oral ulcers ❑ sore throats ❑ ear infections

Are tonsils or adenoids present? ❑ yes ❑ no Approx. Date removed ______________

Does patient play a musical instrument that touches the lips? ❑ yes ❑ no

Is there a history of: ❑ finger sucking ❑ thumb sucking ❑ tongue thrusting

Is the patient a mouth breather? ❑ yes ❑ no

Does the patient snore while sleeping? ❑ yes ❑ no

Is there any history of trauma to the face, jaws, teeth? ❑ yes ❑ no *(please explain)* ________________________

Does the patient have headaches, facial pain or neck aches? ❑ yes ❑ no *(please explain)* ____________________

____

Has jaw ever 'clicked', 'popped', 'locked' or slipped out of place? ❑ yes ❑ no *(please explain)*

____

Does patient clench or grind teeth day or night? ❑ yes ❑ no

Has an orthodontist been consulted previously? ❑ yes ❑ no

Has the patient received previous orthodontic treatment? ❑ yes ❑ no

Is there a history of a negative dental experience? ❑ yes ❑ no

Are there any medical, dental or surgical problems not mentioned above? ❑ yes ❑ no

Please explain: ____

In your own words, please describe the orthodontic problem: ________________________________

____

Does the patient have a history of:
(please check)

- ❑ Allergies
- ❑ Asthma
- ❑ Autoimmune disorder
- ❑ Bleeding/Blood disorder
- ❑ Blood Pressure: high/low
- ❑ Bone disorder
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emotional disorder
- ❑ Endocrine disorder
- ❑ Epilepsy
- ❑ Heart condition
- ❑ Hearing disorder
- ❑ Heart murmur
- ❑ Hepatitis
- ❑ Herpes
- ❑ Kidney disorder
- ❑ Learning disorder
- ❑ Psychological disorder
- ❑ Rheumatic Fever
- ❑ Speech disorder Ringing in ears
- ❑ Sinus infections
- ❑ Sleep disturbance
- ❑ Speech Disorder
- ❑ Venereal disease

DOCTOR'S NOTES

____
____
____
____
____
____
____

Have you ever worn a splint or a mouth guard for TMJ or for clenching? ❑ yes ❑ no *(please explain)* ______________________________

I verify the above and give my consent for Dr. Rutrick to examine the above named patient. Signed: ______________________________ Parent or Guardian