Darron R. Mortenson, DMD, MS 2510 E. Hunt Hwy. Suite 29 ~ Queen Creek, AZ 85243 ~ (480) 457-1623
3011 S. Lindsay Rd. Suite 108 ~ Gilbert, AZ 85295 ~ (480) 963-8001

Child/adolescent form

Referred By____ Date ____
Patient's Name____ Preferred Name ___________________________________
Birthdate _________________ Age_______ Sex______ School___________________________________ Grade_________
Patient's Dentist_____________________________________ Physician ____
Mother's Name _____________________________________ SSN _______________________Date of Birth____________
Home Address____________________________________ Hm Phone ________________ **Email**___________________
City/State/Zip ______________________________________ Work Phone _______________ Cell ____________________
Occupation ____ Employed By ____
Father's Name_______________________________________ SSN_______________________Date of Birth____________
Home Address_______________________________________ Home Phone ____
City/State/Zip ___________________________________ Work Phone __________________ Cell ________________
Occupation ____ Employed By ____
Primary Dental Insurance ______________________________________Phone____
Insured Name____Relationship__________________________________
Name of any family members we have seen ____
Names and Ages of Other Children in the family ____
Person(s) responsible for Payment of Account ____
Address and Relationship to Patient ____

MEDICAL HISTORY

Is the patient in good health?______________ Does the patient have any history of major illness? ____________________
Please list (give dates) ____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

HEART TROUBLE	☐	HIV/AIDS	☐	ATTENTION DEFICIT	☐	LIVER INVOLVMENT	☐
MITRAL VALVE PRO	☐	ANEMIA	☐	KIDNEY PROBLEMS	☐	HEPATITIS	☐
HEART MURMUR	☐	EPILEPSY	☐	ENDOCRINE PROBLEMS	☐	BLOOD DISORDERS	☐
RHEUMATIC FEVER	☐	ASTHMA	☐	PROLONGED BLEEDING	☐	DIABETES	☐
PNEUMONIA	☐	FAINTING OR DIZZYNESS	☐	TUBERCULOSIS	☐	OTHER ___________	☐

Does patient have tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores __________________
Have tonsils and adenoids been removed? _____ What Age? ______ List any drugs or medications now being taken and reason. ____
LIST ANY ALLERGIES OR DRUG SENSITIVITY____
Has the patient reached puberty: Girls-has she started menstruation _____ If so date of onset ____________________
Boys-has his voice changed ____

DENTAL HISTORY

Date of last dental cleaning ___________________________________ Date of last X-rays _________________________
Has the patient had a Panoramic/Panorex X-ray? **Y / N / Don't know** If yes, When? ____________________________
Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _________________________
__________________________________ Has the patient ever sucked a thumb or fingers? **Y /N** Age ________________
Any pain in or near the ears? **Y / N** Does the patient have any speech problems? **Y / N**
Have you been informed of any missing or extra permanent teeth? **Y/ N**
Has an orthodontist been consulted previously? **Y / N** Has either parent had orthodontic treatment? **Y / N**
List any musical instruments played ____
Interests or hobbies ____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature (parent or guardian's) ____ Reviewed By:___________________

OFFICE USE Date ______________________

Chief complaint____

Habits: ____

Trauma ____

TMJ EXAMINATION: Does patient have or report any TMD Symptoms: Y / N TMD History Required: Y / N

Comments: ____

Extra oral exam

Profile: convex-straight-concave **Midface def:** none-mild-moderate-severe **LFH:** long-average-short

Chin: weak-avg-strong **Naso-labial angle:** acute-avg-obtuse **Mento-Labial sulcus:** deep-avg-shallow

Incisor Pro: retrusive-avg-protrusive **Lip incomp:** none-mild-moderate-severe **LipVermillion**: thin-avg-thick

Frontal: Square-Ovoid-Round-Tapering **Symmetry:**

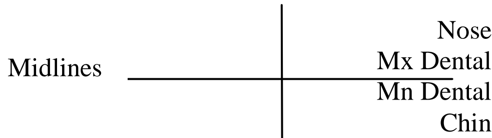
Incisor at rest: **Incisor @ smile**: **Gingiva @ smile**:

Negative Space: none-mild-mod-severe **SmileToothContour:** reverse-flat-avg

Intra oral exam

Frenum: high-avg-low **Diastema:**

Hygiene: 1 2 3 4 5 (5 best) **Attached Gingiva**: **Pathology:**



Notes:____

8	7	6	E 5	D 4	C 3	B 2	A 1	A 1	B 2	C 3	D 4	E 5	6	7	8
8	7	6	5 E	4 D	3 C	2 B	1 A	1 A	2 B	3 C	4 D	5 E	6	7	8

N-ANKYLOSED
C-CARIES
X-EXTRACTED
S-SUPERNUM.
O-CONG. MISSING
A-ABNORM SHAPE
I-IMPACTION
D-DECID.
P-CHIPPED
M-MOBILITY
W-DECALCIFICATION
R-ROOT CANAL TX

	PSR
1	
2	
3	
4	
5	
6	

Crowding/Spacing Maxilla_______mm Mandible_______mm CR/CO________ mm direction _____

Angle class: RM_____ RC_____ LM_____ LC_____ OJ=_______mm OB=_______mm Crossbites______

Comments: ____

RECOMMENDATION

RADIOGRAPHS NEEDED: Pano_____ Lateral Ceph_____ PA Ceph_____ Periapical__________ Other____________________

Interceptive Tx ______________________ Limited Tx ______________________

Full Tx______________________ Habit Tx ______________________

Consults Needed______________________ Extractions______________________

Tx time ______________________ Orthognathic Surgery ______________________

Fee Range ______________________ Stage: One Two Three

Disposition: Recall__________(months) Records ______________________ Will call____________ No tx___

____ N¹V: ______________

____ N²V: ______________

____ N³V: ______________

____ N⁴V: ______________

____ N⁵V: ______________

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❍Insurance confirmed with patient ~ ❍Letter to GD ~ ❍Procedure Letter ~ ❍Pre-authorization sent