Welcome to our Practice!

LEGLER ORTHODONTICS
LEE LEGLER, DMD, MS
Board Certified Orthodontist
www.bracesatlegler.com

PATIENT INFORMATION

Name, Last ______________________ First ______________________ M.I. ______

Family Members Treated ______________________ Birthdate ______ / ______ / ______ ☐ Male ☐ Female

Address ____

City ______________________ State ______________ ZIP ______________

Phone ______________________ Email ______________________

School ______________________ Hobbies/Sports ______________________

Dentist ______________________ Referred by ______________________

RESPONSIBLE PARTY INFORMATION

Name, Last ______________________ First ______________________ M.I. ______

Birthdate ______ / ______ / ______ Social Security Number ________ - ________ - ________

Address ____

City ______________________ State ______________ ZIP ______________

Home Phone (_____) ____________ Work Phone (_____) ____________ Email ______________________

Employer ____

City ______________________ State ______________ ZIP ______________

BILLING PARTY INFORMATION (If Different From Above)

Name, Last ______________________ First ______________________ M.I. ______

Birthdate ______ / ______ / ______ Social Security Number ________ - ________ - ________

Address ____

City ______________________ State ______________ ZIP ______________

Home Phone (_____) ____________ Work Phone (_____) ____________ Email ______________________

Employer ____

City ______________________ State ______________ ZIP ______________

INSURANCE CARRIER INFORMATION

INS. COMPANY	PRIMARY CARRIER	SECONDARY CARRIER
Name		
Address		
City/State/ZIP		
Phone		
Employee		
Policy Number		
S.S. / D.O.B.		

OVER

PATIENT'S MEDICAL HISTORY

Physician's Name Dr. ____________________

Please check any of the following for which you have been diagnosed or treated:

☐ Rheumatic Fever
☐ Prolonged Bleeding
☐ Heart Trouble: Heart Murmur or Mitral Valve Prolapse
☐ Cancer
☐ Cerebral Palsy
☐ Endocrine Problems
☐ Bone Disorders
☐ Asthma
☐ Allergies
☐ Tonsils and Adenoids Removed
☐ Respiratory Diseases
☐ Fainting or Dizziness
☐ Hepatitis
☐ Allergies to latex or metal
☐ Epilepsy
☐ Infectious Diseases
☐ Diabetes

Are you under the care of a physician for a specific condition or taking any medications? ☐ Yes ☐ No

If YES, Explain ____________________

DENTAL HISTORY

	YES	NO
Have you ever been evaluated or had orthodontic treatment before?	☐	☐
Do you have any speech difficulties? Any speech therapy?	☐	☐
Have your teeth or jawbones been injured do to accidents or falls?	☐	☐
Have you been informed of any missing permanent teeth?	☐	☐
Have you ever had any pain/discomfort in the jaw joint (TMJ)?	☐	☐
Do you have any of the following habits? Thumb/finger sucking?	☐	☐
Tongue thrust?	☐	☐
Clenching, grinding teeth?	☐	☐

Briefly describe your major orthodontic concern(s) ____________________

____

Signature: ____________________ Date ____________________

FOR OFFICE USE ONLY

Molars
Class 1 ( )
Class II ( )
Class III ( )
Sub R ( ) L ( )

Cuspids
Cl 1 ( )
Cl II ( )
Cl III ( )
Sub R ( )

Overbite
Open ( )
Normal ( )
Closed Mod. ( )
Severe ( )

Profile
Straight ( )
Convex ( )
Concave ( )
Full ( )

Overjet
Normal ( )
Mod ( )
Severe ( )
m.m. ( )

Crossbite
None ( )
Post ( )
Ant ( )

Arch Symmetry
Max ( )
Mand ( )

Midline off
Max ( )
Mand ( )
Right ( )
Left ( )

Crowding
Max Mod ( ) Severe ( )
Mand Mod ( ) Severe ( )

TMJ
R ( ) L ( )

Missing Teeth

Teeth to be Extracted

Impacted Teeth

Caries

Chief Complaint ____________________

Skeletal relationship: Class I ☐ Class II ☐ Class III ☐

Arch Length: Maxillary__________mm adequate ☐ excessive ☐ deficient ☐ Caries
Mandibular__________mm adequate ☐ excessive ☐ deficient ☐ ______|______

TMJ: normal ☐ symptomatic ☐ early click R L late click R L
popping R L crepitus R L pain R L max. opening ________mm
Late. Exc.: Crep R L Click R L Pain R Lim. movement ☐
Mom ☐ Dad ☐ popping ☐ cracking ☐ locking ☐ treatment ☐

Muscles: Trapezius ☐ SCM ☐ Masseter ☐ Temporal ☐ Suprahyoids ☐ Medial Pterygoids ☐ Lateral Pterygoids ☐

Facial Asymm: deviated to: R L max. ☐ mand. ☐

Lip Posture: upper lip: OK ☐ short ☐ gummy smile ☐ tick ☐ thin ☐ tight ☐
lower lip: OK ☐ short ☐ shows excessive lower incisors ☐ tight ☐

Nasolabial Angle: obtuse ☐ acute ☐ adequate ☐ eversion ☐ thick ☐ thin ☐ U. lip length______mm L length______mm

Perioral Musc.: hypo ☐ hyper ☐ mentalis ☐

Myofunctional: anterior tongue thrust ☐ lateral tongue thrust ☐ lip incompetency ☐ high vault ☐ normal ☐

Airway: adequate ☐ occluded ☐ enlarged tonsils ☐ mouth breather ☐

Tongue: large ☐ anterior posture ☐ tied ☐ tooth impressions ☐ normal ☐
thrust: ☐ ant/post ☐ lat. ☐ speech ☐ swallowing ☐

Speech: normal ☐ s/z ☐ Th ☐ R ☐ slow ☐ other____________________

Frenum: poss. surg. of max ☐ mand. ling. ☐ mand. lab. ☐

Occlusal wear: slight ☐ severe ☐ moderate ☐ __________|__________

Gingiva: inflamed ☐ hyperthrophied ☐ recessed ☐ pockets ☐ __________|__________

Oral Hygiene: good ☐ fair ☐ poor ☐ __________|__________

Habits: thumb: R L finger: #__________
lip biting ☐ lip sucking ☐ tongue sucking ☐
sleeping: ☐ side ☐ stomach ☐

Saliva: Excessive ☐ Thick Saliva ☐

Difficult mouth to work in ☐