CAPOGNA ORTHODONTICS
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CASE ANALYSIS RECORD – ADULT

Case # _____
Date _____

DEMOGRAPHIC DATA

Name _____ Nickname _____
Age_____ Birthdate_____ Home Phone_____ Cell Phone_____
Street_____ Apartment_____
City_____ State_____ Zip_____ E-mail_____
Employed by_____ How long_____
Address_____ Zip_____ Bus. Phone_____
Dental Insurance Plan_____
Group#_____ Agreement #_____ Soc. Sec. #_____

Spouse's full name_____
Employed by_____ How long_____
Address_____ Zip_____ Bus. Phone_____
Dental Insurance Plan_____
Group#_____ Agreement #_____ Soc. Sec. #_____

GENERAL APPRAISAL

Chief Complaint (Reason for consultation)_____
Previous Orthodontic Treatment No Yes _____
Does problem resemble that of Father Mother Sibling(s)
Are you aware that success of orthodontic treatment depends on cooperation? Yes No

MEDICAL HISTORY

Physician _____ Last Med. Exam_____
Address_____
Currently under medical treatment No Yes _____
History of recent illness No Yes _____
Currently taking medication No Yes _____
Have you ever been hospitalized No Yes _____
Have you ever had an operation No Yes _____
Allergic history to medicines No Yes _____
Foods No Yes _____
Other No Yes _____

Do you have history of: (circle all that apply)

Anemia	Diabetes	Heart disorders
Asthma	Endocrine disorders	Kidney disorders
Bleeding problems	Epilepsy	Liver involvement
Bone disorders	Fainting or dizziness	Rheumatic fever

Comments _____

Please discuss any other medical conditions (not listed above) : _____

_____

DENTAL HISTORY

Dentist _____ Last Dental Exam _____
Address _____
Injuries to face/mouth/teeth No Yes _____
Grinding or clenching No Yes (Day / Night)
Soreness or clicking in joint No Yes (Left / Right)

WHOM MAY WE THANK FOR YOUR REFERRAL? _____