

Dental History Information

Have you had a previous orthodontic consultation or treatment?

Yes No Date: _____ Dr.: _____

Has any other family member had orthodontic treatment?

Yes No Date: _____ Dr.: _____

Do you brush your teeth daily? Yes No
How often? _____

Do you floss daily? Yes No

Do you have any speech problems? Yes No

Have you ever received or been requested to receive speech therapy? Yes No

Have you ever injured a tooth? Yes No

Was injury due to an accident or A blow to the mouth? Yes No

Have you ever had an injury to your head, face or neck? Yes No

Habits:

Thumb or finger sucking until age: _____

Lip biting or sucking Yes No

Grinding Yes No

Tongue thrusting Yes No

Have you had any unusual dental experiences? Yes No

Explain: _____

Are you presently under a dentist's care? Yes No

Explain: _____

Have you ever:

- Been told that you have gum disease?
- Had a problem with bleeding gums?
- Been treated for gum disease (periodontal)?
- Had permanent teeth removed?
- Been told a filling or a cavity is close to the nerve?
- Had a root canal treatment (endodontal)?
- Had clicking noises when opening or closing your mouth?
- Had muscle pains around your jaw joint?
- Had treatment for jaw joint pain?
- Had chronic ear aches?

Do you have any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Overbite | <input type="checkbox"/> Buck Teeth |
| <input type="checkbox"/> Receded Jaw | <input type="checkbox"/> Prominent Jaw | <input type="checkbox"/> Jaw Dysfunction |
| <input type="checkbox"/> Gummy Smile | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Mouth Too Small |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Spaces | <input type="checkbox"/> Protrusion of Teeth |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Abnormal Profile | |
| <input type="checkbox"/> Gum Disease/Recession | | |
| <input type="checkbox"/> Irregularly Shaped Teeth | | |
| <input type="checkbox"/> Ringing/Stuffiness of Ears | | |

Any additional comments you wish to make?

Medical History Information

Physician: _____ City: _____

Last Exam: _____ General Health: _____

Have you ever had:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Female Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Sleep Disturbance | | |

Are you presently under physicians care? Yes No

If yes, explain:

Respiratory History Information

Do you have allergies? Yes No

Do you snore when sleeping? Yes No

Do you have frequent colds? Yes No

Do you have frequent stuffy noses? Yes No

Do you have frequent sore throats or tonsillitis? Yes No

Do you have chewing or swallowing difficulty? Yes No

Do you breath through your mouth? Yes No

Are your tonsils or adenoids removed? Yes No

Do you have other family members who might benefit from an orthodontic evaluation?

Name and Age: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature of Individual completing this form _____

Date _____

Signature of Orthodontist _____

Date _____