DENTAL HISTORY

ORAL HEALTH: ☐Excellent ☐Good ☐Fair ☐Poor

Date of Last Dental Visit:____________________ Allergic to Latex? ☐Y☐N

☐Y ☐N Are you currently having dental discomfort? If yes, explain: ______________________________

☐Y ☐N Any unhappy/unpleasant dental experiences? If yes, explain: ____________________________

☐Y ☐N Any injuries to mouth/teeth/head? If yes, explain: ______________________________________

☐Y ☐N Any missing teeth other than wisdom teeth or extra permanent teeth?

☐Y ☐N Have you been evaluated by an orthodontist or had orthodontic treatment in the past?

☐Y ☐N Gums bleed when brushing or flossing? How often do you floss? ____________ Brush? ______

☐Y ☐N Any concerns about the appearance of your teeth/smile?

☐Y ☐N Have you ever had any pain or tenderness in your jaw joint (TMJ or TMD)?

☐Y ☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y ☐ N

☐Y ☐N Does any type of dental treatment make you nervous? If yes, please explain below:

____

What are the main concerns you would like orthodontics to address?

____

Does the patient have any of the following habits?

☐Y ☐N Thumb/Finger Sucking?

☐Y ☐N Lip sucking/Biting?

☐Y ☐N Clenching/Grinding?

☐Y ☐N Mouth Breather?

☐Y ☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

____

☐Y ☐N Nail Biting?

☐Y ☐N Tongue Thrust?

☐Y ☐N Any unusual speech habits? If yes, explain:

____

PRIMARY PHYSICIAN INFORMATION

Physician: ______________________________________Telephone: ___________________________

Clinic/Facility: ____

MEDICAL HISTORY

GENERAL HEALTH: ☐Excellent ☐Good ☐Fair ☐Poor

☐Y☐N Are you under a physician's care now?

☐Y☐N Are you taking prescription/OTC drugs? List: ____

☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y☐N Has puberty begun? ☐Y☐N Are you pregnant?
☐Y☐N Has menstruation begun? ☐Y☐N Are you taking birth control pills?

ALL PATIENTS: Do you have, or have you ever had any of the following? (Check all that apply):

☐ADHD	☐Blood Disorder	☐Epilepsy/Seizures	☐Respiratory Disease
☐AIDS/HIV	☐Cancer/Malignant	☐Heart Murmur	☐Sinus Problems
☐Anemia	☐Cerebral Palsy	☐Heart Problems	☐Tuberculosis
☐Anxiety	☐Dizziness/Fainting	☐Herpes – Any type	☐Other-Please list
☐Autism/Asperger's	☐Endocrine Disorder	☐Hepatitis	

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ALL PATIENTS: Are you allergic to or have you ever had any reaction to? (Please List): or ☐None

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