

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?

- Crowding Overbite Buck Teeth
- Receded Jaw Prominent Jaw Jaw Dysfunction
- Gummy Smile Neck Pain Mouth Too Small
- Missing Teeth Spaces Protrusion of Teeth
- Jaw Pain Abnormal Profile
- Gum Disease/Recession
- Irregularly Shaped Teeth
- Ringing/Stuffiness of Ears

Any additional comments you wish to make?

Medical History Information

Physician: _____ City: _____

Last Exam: _____ General Health: _____

Have you ever had:

- Allergies Arteriosclerosis Asthma
- Autoimmune Disorder Blood Disease Diabetes
- High Blood Pressure Low Blood Pressure Cancer
- Bone Disorders Female Problems Epilepsy
- Endocrine Problems Emotional Problems Hepatitis
- Heart Disease Hearing Disorder Dizziness
- Kidney Disease Rheumatic Fever Tuberculosis
- 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 _____