Last Name _____ First Name _____ Age _____
Reason for this appointment? _____

DENTAL HISTORY

(Please circle the appropriate answer)

Any previous orthodontic treatment?	NO	YES
Any baby teeth or permanent teeth removed by a dentist?	NO	YES
Any major falls or accidents involving the head, face or teeth?	NO	YES
Any difficulty breathing through the nose (awake or asleep)?	NO	YES
Any clenching of teeth or grinding teeth at night?	NO	YES
Does anyone else in your family have similar dental problems?	NO	YES

Dentist Name _____ Date teeth last cleaned _____

HEALTH HISTORY

(Please circle if you have or had any of the following)

Tonsils and/or adenoids removed? NO YES Rheumatic fever? NO YES
Heart Murmur? NO YES Diabetes? NO YES
Drugs or other allergies? NO YES if yes, explain _____
Environmental allergies (such as dogs, cats, trees, etc.)? NO YES
if yes, explain _____
Any Drugs or **NSAIDS** (Advil, Motrin) taken regularly? NO YES
Any Osteoporosis medications? NO YES (ex Fosmax, Boniva) _____
Any other health problems? NO YES if yes, explain _____
Any behavior problems NO YES
Have you ever tested positive for HIV or Hepatitis? NO YES
Are you in good health now? NO YES
Have you ever had a serious illness or injury? NO YES
If yes, explain _____
Please provide your Medical Doctor's name _____
How did you hear about our office? _____

GENERAL INFORMATION

Residence address _____ Birthdate _____
_____ Social Security No. _____
Home Address _____ Home Phone _____
_____ Cell Phone _____
Email Address _____
Place of Employment _____
Position _____ Employer's Phone _____
Do you have Dental Insurance? NO YES If yes, what provider? _____
Orthodontic Coverage NO YES If yes, at what coverage? _____
Does your spouse have dental insurance that provides coverage for you also NO YES
Spouse Name _____ SSN _____
Spouse Birthdate _____
Are there special arrangements regarding billing of these procedures? _____
_____
What is your preferred method of contact? □ Home # □ Cell # □ Email □ Text
Please print contact information _____

I understand that the information that I have given on the Dental and Medical history for and the information given to the Doctor are correct and complete to the best of my knowledge, and that it is my responsibility to inform the Doctor of any change in my child's medical or dental status.

Date _____ Signature _____

Note: THIS SIDE IS TO BE COMPLETED BY THE DOCTOR

CUSPIDS: Class I II III MOLARS: Class I II III

TEETH:

Retained deciduous

E D C B A	A B C D E
E D C B A	A B C D E

Permanent Present

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Permanent Missing

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Crowding

Mx _____ Ma _____

X-Bite _____

Overbite _____ %

Overjet _____ mm

Midline

a) Upper
b) Lower

Tongue Thrust _____

Swallow YES NO

Musculature _____

Oral Hygiene _____

Habits _____

Path of Closure _____

Attitude towards RX _____

Comments _____

Misc. _____

Date _____ RX _____