WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

PERSONAL HISTORY

Name: _____Birth date: _____/____/_____
Address: _____ Age: _____ Sex: M/F
Postal Code: _____ Email Address: _____
Home Telephone #: _____/_____/_____ School: _____ Grade: _____
Family Dentist: _____ City: _____ Phone#: _____
Family Doctor: _____ City: _____ Phone#: _____
Reason for seeing an orthodontist: _____

(To be filled out by Parent/Guardian if patient is under 18 years of age)
Fathers Name:_____ Occupation:_____
Home Telephone#: _____ Cell Phone#: _____
Email Address: _____Employer: _____
Work Phone #: _____Dental Insurance: Yes/No Company: _____
Policy#: _____ Contract#: _____

Mothers Name: _____ Occupation:_____
Home Telephone#: _____ Cell Phone#: _____
Email Address: _____Employer: _____
Work Phone #: _____Dental Insurance: Yes/No Company: _____
Policy#: _____ Contract#: _____

Health Questionnaire

Please circle the correct answer. A brief description of the problem is also helpful.

Serious Illnesses			Operations		
Polio	NO	YES	Tonsils	NO	YES
TB	NO	YES	Adenoids	NO	YES
Rheumatic Fever	NO	YES	Transfusions	NO	YES
Heart Damage	NO	YES	Other Operations: _____		
Thyroid Condition	NO	YES			
Diabetes	NO	YES	Bleeding From Wounds		
Earaches	NO	YES	Normal Excessive		
Sore Throats	NO	YES			
Epilepsy	NO	YES	Breathing Nose Mouth		
Hepatitis	NO	YES			
Hemophilia	NO	YES	Allergies		
AIDS	NO	YES	Hayfever	NO	YES
Herpes	NO	YES	Dental Materials	NO	YES
Venereal Disease	NO	YES	Drugs	NO	YES
Other: _____			Latex	NO	YES

How long since your last dental visit: _____

Are you taking any medication?	NO	YES
Are you under a doctor's care?	NO	YES
Are you pregnant?	NO	YES
Have you had pervious ortho treatment?	NO	YES
Other family members who have had ortho?	NO	YES

Any particular concerns about having braces?
_____
_____
_____
_____
_____

Serious Injuries

Head	NO	YES
Face	NO	YES
Teeth	NO	YES

Brief description: _____

_____

Describe any other medical problems: _____

_____

_____

Oral Habits

Grinding of Teeth	NO	YES
Thumb Sucking	NO	YES
Finger Sucking	NO	YES

When stopped? _____

Chewing difficulties	NO	YES
Speech Problems	NO	YES
Speech Therapy	NO	YES
Gagging	NO	YES

Tooth Eruption	Average	Early	Late
Fillings	None	Few	Many
Bleeding Gums	Never	Occasionally	Frequently
Extractions	Primary teeth		Permanent teeth

Jaw Joint Pain	NO	YES
Facial Pain	NO	YES

Difficulty or Pain, or both, when opening your mouth
As for instance yawning? NO YES
Does your jaw get "stuck", "locked", or
"go out"? NO YES
Difficulty or pain, or both, when chewing
Or talking? NO YES
Are you aware of noises in the jaw or joints?
NO YES
Do you have pain in or about the ears, temples,
Or cheeks? NO YES
Does your bite feel unusual or uncomfortable?
NO YES

Contact Sports NO YES
Which sports? _____ _____

Musical Instruments with Mouth
Which instrument? _____
Years played? _____
Practice time? _____

Growth and Development

Recent Rapid Growth	NO	YES
Recent Decline in Growth	NO	YES
Record of Height Available	NO	YES

Girls

Any signs of puberty?	NO	YES
Has menstruation started?	NO	YES

Approx start date? _____

Boys

Any signs of puberty?	NO	YES
Voice change?	NO	YES
Beard?	NO	YES

Height
Your height _____ Weight _____
Father's height _____
Mother's height _____

Do you have any frequent headaches? NO YES
Have you had a recent injury to your head,
neck, or jaw? NO YES
Have you previously been treated for a jaw
or joint problem? NO YES
If so, when? _____
_____
Doctor When

Signed: _____ Date: _____
Signatures (if 18 years of age)

Signed: _____ Date: _____
Parent or Guardian