CONFIDENTIAL

Member
American Association of Orthodontists

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ADULT

Patient's Last Name ____________________ First ______________ Middle ________________
Name of Patient's Dentist ____________________ Dentist's Phone No. ____________________
Dentist's Address ____

For the following questions circle yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

1. Chipped or otherwise injured permanent teeth?_____**yes no d/k**
2. Teeth sensitive to hot or cold; teeth throb or ache? **yes no d/k**
3. Jaw fractures, cysts, mouth infections?_____**yes no d/k**
4. "Dead Teeth", root canals treated?_____**yes no d/k**
5. Bleeding gums, bad taste, or mouth odor?_____**yes no d/k**
6. Periodontal "Gum Problems"?_____**yes no d/k**
7. Food impaction between teeth?_____**yes no d/k**
8. "Gum Boils", frequent canker sores, cold sores?_____**yes no d/k**
9. Thumb, finger, sucking habit? Until_____**yes no d/k**
10. Abnormal swallowing habit (tongue thrusting)?_____**yes no d/k**
11. Mouth breathing habit, snoring, difficulty in breathing?_____**yes no d/k**
12. Tooth grinding, jaw clenching, clicking, or locking?_____**yes no d/k**
13. Any pain in jaw or ringing in the ears?_____**yes no d/k**
14. Does the patient experience any pain or soreness in the muscles of the face or around the ears?_____**yes no d/k**
15. Difficulty encountered in chewing or jaw opening? _____**yes no d/k**
16. Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain)?_____**yes no d/k**
17. History of supernumerary (extra) or congenitally missing teeth?_____**yes no d/k**
18. Have any permanent teeth been removed?_____**yes no d/k**
19. Aware of loose, broken or missing restorations (fillings)?_____**yes no d/k**
20. Any teeth irritating cheek, lip, tongue, palate?_____**yes no d/k**
21. Concerned about spaced, crooked, protruding teeth?_____**yes no d/k**
22. Aware or concerned about under or over developed jaw?_____**yes no d/k**
23. Any relative with similar tooth or jaw relationships? _____**yes no d/k**
24. Any wisdom tooth problems?_____**yes no d/k**
25. Has patient had any serious trouble associated with any previous dental treatment?_____**yes no d/k**
26. Has patient ever had a prior orthodontic treatment or worn a "retainer" or "bite plate"?_____**yes no d/k**
27. Has patient recently been under another dentist's care?_____**yes no d/k**

    Specialist_____________________

    Other_____________________
28. Has patient ever had periodontal (gum) treatment?_____**yes no d/k**

Date of most recent dental examination__________

How often does patient brush ________floss________

What is the patient's (or parent's) primary concern? -- Why are you here?____________________

____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

____

____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this dental status I will so inform this practice.

____
Signature of Patient Date

DENTAL HISTORY