

CONFIDENTIAL

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FOR PATIENTS UNDER 18 YEARS OF AGE

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. Started teething very early or late? _____ **yes no d/k**
- 2. Primary (baby) teeth removed that were not loose? _____ **yes no d/k**
- 3. Permanent or "extra" (supernumerary) teeth removed? _____ **yes no d/k**
- 4. Supernumerary (extra) or congenitally missing teeth? _____ **yes no d/k**
- 5. Chipped or otherwise injured primary (baby) or permanent teeth? _____ **yes no d/k**
- 6. Teeth sensitive to hot or cold; teeth throb or ache? _____ **yes no d/k**
- 7. Jaw fractures, cysts, mouth infections? _____ **yes no d/k**
- 8. "Dead Teeth", root canals treated? _____ **yes no d/k**
- 9. Bleeding gums, bad taste, mouth odor? _____ **yes no d/k**
- 10. Periodontal "Gum Problems"? _____ **yes no d/k**
- 11. Food impaction between teeth? _____ **yes no d/k**
- 12. "Gum Boils", frequent canker sores, cold sores? _____ **yes no d/k**
- 13. Is child taking any forms of fluoride? _____ **yes no d/k**
- 14. Thumb, finger, sucking habit? _____ **yes no d/k**
Until _____
- 15. Abnormal swallowing habit (tongue thrusting)? _____ **yes no d/k**
- 16. History of speech problems? Stammer Lisp _____ **yes no d/k**
- 17. Mouth breathing habit, snoring, difficulty in breathing? _____ **yes no d/k**
- 18. Tooth grinding, jaw clenching, clicking, locking? _____ **yes no d/k**
- 19. Any pain in jaw or ringing in the ears? _____ **yes no d/k**
- 20. Does the patient experience any pain or soreness in the muscles of the face or around the ears? _____ **yes no d/k**
- 21. Difficulty encountered in chewing or jaw opening? _____ **yes no d/k**
- 22. Aware of loose, broken or missing restorations (fillings)? _____ **yes no d/k**
- 23. Any teeth irritating cheek, lip, tongue, palate? _____ **yes no d/k**
- 24. Concerned about spaced, crooked, protruding teeth? _____ **yes no d/k**
- 25. Aware or concerned about under or over developed jaw? _____ **yes no d/k**
- 26. Any relative with similar tooth or jaw relationships? _____ **yes no d/k**
- 27. Any wisdom tooth problems? _____ **yes no d/k**

- 28. Has patient had any serious trouble associated with any previous dental treatment? _____ **yes no d/k**
- 29. Onset of puberty (approximate date)? _____ **yes no d/k**
- 30. Has patient ever had a prior orthodontic examination or treatment? _____ **yes no d/k**
- 31. Has patient recently been under another dentist's care? **yes no d/k**
Specialist _____
Other _____
- 32. Has patient ever had periodontal (gum) treatment? _____ **yes no d/k**
- 33. Would patient object to wearing orthodontic appliances (braces) should they be indicated? _____ **yes no d/k**
- 34. Does patient brush his/her teeth conscientiously? _____ **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 parent or guardian

Date