Patient Dental Information

*Dentist*_____*Approximate Date of Last Visit*_____
*How did you hear about our office?*_____

Toothbrushing Schedule per Day (Circle) 1X 2X 3X 4+ Flossing (Circle) Yes No Daily Infrequently

Areas of Concern *(Circle all that apply):*

Crowding	*Protrusion*	*Cross-bite*	*Missing Teeth*	*Extra Teeth*
Jaw Soreness	*Gum Problems*	*Speech Problems*	*Bite Off*	*Slow Eruption Adult Teeth*

History of the following *(Circle all that apply):*

Trauma to Teeth/Face	*Mouthbreathing*	*Snoring*	*Tongue Thrust*
Finger/Thumb Sucking	*Grinding*	*Clenching*	*Headaches/Earaches*
Clicking by ear when open	*Jaw gets stuck open/closed*	*Pain in Jaw Joint*	*Previous orthodontic treatment*

*Family pattern of bite problem (Explain)*_____

Patient Medical History

*Physician*_____*Approximate Date of Last Visit*_____

*Currently on Medication: (Circle) Yes No If Yes, List*_____

Any History of Allergies or Allergic Reaction to the following *(Circle all that apply):*

Penicillin or other Antibiotics	*Sulfa Drugs*	*Aspirin*	*Tylenol(Acetominophen)*
Advil(Ibuprophen)	*Latex*	*Nickel*	*Local Anesthetics(Novocaine)*
Pollen/Seasonal	*Animals*	*Foods (List)*_____	

Medical and Disease History *(Circle all that apply):*

AIDS/HIV Positive	*Anemia*	*Arthritis*	*Artificial Heart Valves/Joints*
Asthma	*Back/Neck Problems*	*Bleeding Problem*	*Blood Disease (list)*_____
Cancer	*Chemotherapy*	*Cold Sores*	*Congenital Heart Murmur/Problems*
Diabetes	*Epilepsy*	*Emotional Problems*	*Hepatitis (list type)*_____
Kidney Problems	*Liver disease/Jaundice*	*Migraines*	*Under Care of Psychologist/Psychiatrist*
Radiation Treatment	*Rheumatic Fever*	*Skin problems/Rashes*	*Stroke*
Tuberculosis	*Venereal Disease*	*Vision/Hearing Deficiency*	*Other*_____

Other Concerns

To get the best result, orthodontic treatment relies on good patient <u>cooperation</u> (i.e. good brushing, wearing elastics, not breaking braces loose from teeth, not eating hard or sticky foods). With this in mind, is there anything that would prevent this type of cooperation?

(Please circle) Yes No
If yes, please explain_____

Orthodontic treatment also uses diagnostic x-rays prior to treatment and during treatment to monitor treatment response and dental health, would you like (please circle the following):

Take appropriate x-rays as necessary Inform prior to taking any film Take no x-rays

Authorization

I have completed this form fully. The information provided is complete and correct. I agree to inform this office of any change(s) at the next visit. I permit use of the patient records for presentation at scientific meetings. I acknowledge that the financially responsible person named above is responsible for all charges and balances remaining after insurance. I permit review of my credit history for preparation of financial arrangements. I acknowledge receipt of "Notice of Privacy Practices".

_____ _____
Signature *Print Name*