ADULT ORTHODONTIC CONSULTATION

GENERAL INFORMATION

Name ______________________________ Home Phone __________
Address ______________________________
City __________ Zip __________ How long at this address? __________
Social Security Number ______ - ______ - ______ Date of Birth __________ Age ______
Occupation __________ Business Phone __________ Is it OK to call? Yes No
Employer ______________________________
Marital Status (Check one) Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)
Spouse's Name __________ Occupation __________
Employer ______________________________
Social Security Number ______ - ______ - ______ Business Phone __________ Is it OK to call? Yes No
Family Dentist __________ City __________
Family Physician __________ City __________
Whom will be responsible for payment of this account? __________
Address (if different) __________ Employed by (if different) __________
Is there orthodontic insurance? ______ With whom? __________
I understand that if I choose extended payments for services that a credit report may be necessary.
Sign here ______________________________
Whom may we thank for referring you to this office? __________
In your own words, what is the problem? __________
____
Who first noticed this problem? Self ☐ Dentist ☐ Other ☐ When? __________
Would you change anything about your teeth or smile? __________
____
What do you expect from treatment? __________
Are there any of your family members who have had treatment at our office? Yes ☐ No ☐
List their name(s) ______________________________

DENTAL HISTORY (THIS INFORMATION IS CONFIDENTIAL AND FOR OUR USE ONLY):

Have you seen an orthodontist previously? ______ Was treatment provided? ______ When? ______
How many times do you brush daily? ______ Do you: Floss? Yes ☐ No ☐ How often? ______
Do you: Smoke? Yes ☐ No ☐ How many packs per day? ______
Over the last five years have you maintained routine dental check ups? . . . . Yes No
How Often? __________
Have you ever had a serious dental disease? . . . . Yes No
Have you ever had teeth extracted, including wisdom teeth? . . . . Yes No
When? __________
Do you have any missing back teeth with no replacements? . . . . Yes No
Do you wear a removable partial or full denture? . . . . Yes No
Do you have any dental crowns or bridges? . . . . Yes No
Have you ever been treated for a jaw joint problem or facial muscle spasms? . . . . Yes No
Have you ever had a jaw splint or mouth guard? . . . . Yes No

(DENTAL HISTORY CONTINUED)

Have you ever had an equilibration by your family dentist to adjust your bite? .... Yes ☐ No ☐
Have you ever noticed popping or clicking noises in your jaws? .... Yes ☐ No ☐
Do you have difficulty opening or closing your mouth? .... Yes ☐ No ☐
Do you have difficulty eating or chewing? .... Yes ☐ No ☐
Do you chew gum frequently? .... Yes ☐ No ☐
Do you clench your teeth or grind them at night? .... Yes ☐ No ☐
Do you bite your nails or have any other oral habits? .... Yes ☐ No ☐
Are you frightened or anxious about dental treatment? .... Yes ☐ No ☐
Have you ever had an unpleasant experience in a dental office? .... Yes ☐ No ☐
Do you have any special concerns about orthodontic or TMJ treatment? .... Yes ☐ No ☐

MEDICAL HISTORY (THIS INFORMATION IS CONFIDENTIAL AND FOR OUR USE ONLY):

Have you ever had:

- Tonsils and adenoids removed? .... Yes ☐ No ☐
- Rheumatic fever, or heart disease? .... Yes ☐ No ☐
- Arthritis or inflammatory rheumatism? .... Yes ☐ No ☐
- Trauma to the head, face, or teeth? .... Yes ☐ No ☐
- Surgery of the head or face? .... Yes ☐ No ☐
- High or low blood pressure or cardiovascular disease? .... Yes ☐ No ☐
- Blood disorders? .... Yes ☐ No ☐
- Drug or other allergy, hay fever, asthma? .... Yes ☐ No ☐
- Difficulty breathing through nose (awake and/or asleep)? .... Yes ☐ No ☐
- Frequent headaches or migraines? .... Yes ☐ No ☐
- Sinus problems? .... Yes ☐ No ☐
- Earaches or ear infections? .... Yes ☐ No ☐
- Any speech problems? .... Yes ☐ No ☐
- Frequent neck or backaches? .... Yes ☐ No ☐
- A low pain tolerance? .... Yes ☐ No ☐
- Stomach ulcers or digestive problems? .... Yes ☐ No ☐
- Eating disorders? .... Yes ☐ No ☐
- Any other health problems? .... Yes ☐ No ☐

Have you ever been tested for HIV or Hepatitis? .... Yes ☐ No ☐
To your knowledge have you ever had a positive test for HIV (any AIDS test) or been exposed to HIV? .... Yes ☐ No ☐
To your knowledge have you ever had a positive test for Hepatitis or been exposed to Hepatitis? .... Yes ☐ No ☐
Do you take any medication regularly? .... Yes ☐ No ☐

What? ______________________________

Have you ever had an adverse reaction to any medicine? .... Yes ☐ No ☐
Have you been hospitalized in the last 10 years? .... Yes ☐ No ☐
Have you ever heard ringing or noises in your ears? .... Yes ☐ No ☐
Ever been treated for a nervous disorder? .... Yes ☐ No ☐
Do you take sedatives, tranquilizers, nerve medicine, or sleeping pills? .... Yes ☐ No ☐
An unusual amount of stress in your life? .... Yes ☐ No ☐
Have you ever had a serious medical problem or operation? .... Yes ☐ No ☐
Are you under the care of a doctor? .... Yes ☐ No ☐
Do you consider yourself healthy? .... Yes ☐ No ☐
FEMALES — Are you pregnant or nursing? .... Yes ☐ No ☐

IF THERE ARE CHANGES IN HEALTH, PLEASE INFORM US.

Please explain below any "Yes" answers.

PEDIATRIC ORTHODONTIC CONSULTATION

GENERAL INFORMATION

Patient's Name________________ Nickname________________

Address________________

City________________ Zip________________ How long at this address?________________

Social Security Number______-______-______ Date of Birth________________ Age________

Home Phone________________ Height________ Weight________

Family Dentist________________ City________________ Last Visit________________

Family Physician________________ City________________

School________________ Grade________ Teacher's Name________________

Musical Instruments________________ Sports________________ Hobbies________________

Father's Name________________ Occupation________________

Employer________________

Social Security Number______-______-______ Business Phone________________ Is it OK to call? Yes ☐ No ☐

Mother's Name________________ Occupation________________

Employer________________

Social Security Number______-______-______ Business Phone________________ Is it OK to call? Yes ☐ No ☐

Parents' Marital Status (Check one) Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐

Whom will be responsible for payment of this account?________________

Address (if different)________________ Employed by (if different)________________

Is there orthodontic insurance?________ With whom?________________

I understand that if I choose extended payments for services that a credit report may be necessary.

Sign here________________

Whom may we thank for referring you to this office?________________

HISTORY

(These answers are very helpful to us in obtaining a better understanding of the patient's orthodontic problem. The answers are confidential, for our office use only.)

In your own words, what is the problem?________________

____

Who first noticed this problem? Parent ☐ Patient ☐ Dentist ☐ Other ☐ When?________________

Does the patient have any special concerns about undergoing Orthodontic Treatment? Yes ☐ No ☐

What do you expect from treatment?________________

Has the patient seen an orthodontist previously?________ Any treatment?________ When?________________

Has any family member been in treatment at our office? Yes ☐ No ☐ Patient's Name________________

Number of children in the family________ Ages ______ ______ ______ ______ ______ ______ ______

Does anyone else in the family have a similar problem? Yes ☐ No ☐ Who?________________

General development resembles: Neither parent________ Father________ Mother________

Father's height________________inches Mother's height________________inches

Any problems during pregnancy or birth?________________

Any clicking, popping, or other noises when opening or closing jaw? .... Yes ☐ No ☐
Any major falls or accidents involving the head, face or teeth? .... Yes ☐ No ☐
Any baby or permanent teeth removed by your dentist? .... Yes ☐ No ☐
Any difficulty breathing through the nose (awake and/or asleep)? .... Yes ☐ No ☐
Any habits such as nail biting, thumbsucking, lip biting? .... Yes ☐ No ☐
Any speech problems? .... Yes ☐ No ☐
Any difficulty opening mouth wide? .... Yes ☐ No ☐
Has the patient ever had an unpleasant experience in a dental office? .... Yes ☐ No ☐
Has the patient had any of the following:

- Tonsils and adenoids removed? .... Yes ☐ No ☐
- Rheumatic fever or heart disease? .... Yes ☐ No ☐
- Drug or any other allergy, hay fever, asthma? .... Yes ☐ No ☐
- Diabetes? .... Yes ☐ No ☐
- Anemia? .... Yes ☐ No ☐
- Blood disorders? .... Yes ☐ No ☐
- Is pre-medication necessary before treatment due to medical reasons? Example: Heart .... Yes ☐ No ☐
- Drugs taken regularly? .... Yes ☐ No ☐
- Other health problems? .... Yes ☐ No ☐
- Has the patient ever been tested for HIV or Hepatitis? .... Yes ☐ No ☐
  - To your knowledge has the patient ever had a positive test for HIV (any AIDS test) or been exposed to HIV? .... Yes ☐ No ☐
  - To your knowledge has the patient ever had a positive test for Hepatitis or been exposed to Hepatitis? .... Yes ☐ No ☐

Please explain any "YES" answers ____________________

____

____

If adolescent, has the patient shown signs of puberty? Yes ☐ No ☐ At what age? ____________

Does the patient desire orthodontic treatment? ____________________

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Please explain below any "Yes" answers.