



ADULT

Getting to Know You:

DATE _____

PATIENT'S NAME _____ AGE _____ SEX _____ BIRTHDATE _____

Address _____ City & Zip _____ Phone _____

Occupation _____

Employer _____ Address _____ Phone _____

Husband/Wife Name _____ Occupation _____

Employer _____ Address _____ Phone _____

Patient's Dentist _____ Physician _____

Whom may we thank for referring you to us? _____

Do you anticipate a move or transfer in the next 6-12 months? Yes No

Does patient have orthodontic insurance? Yes No

DENTAL HISTORY

Patient's dentist _____ Date of last visit _____

Address _____ Phone _____

PLEASE CIRCLE YES OR NO

Have you had the following treatment?

- Previous orthodontic exam or treatment? . . . Yes No
- Extractions (teeth removed)? Yes No
- Periodontal (gum) treatment? Yes No
- Endodontic (root canal) therapy? Yes No
- TMJ (jaw joint) problems or therapy? Yes No
- Mouthguard/splint (plastic device
between teeth), surgery or chiropractic? . Yes No

Are you aware of any of the following problems?

- Clicking, popping or grating noise in your jaw joints? Yes No
- If yes, does it bother you? Yes No
- Clenching or grinding of your teeth? Yes No
- Frequent toothaches or sensitive teeth? Yes No
- Food catching or collecting between your teeth? Yes No
- Sores, lumps or irritated areas in your mouth? Yes No
- Numbness or pain in your mouth, jaw joints or face? Yes No

History of mouth breathing, finger or thumb sucking, nail biting? Yes No

History of injury to face, head or teeth? Yes No

Have tonsils and adenoids been removed? _____ Date _____

Would patient mind wearing "braces" if necessary? Yes No

Describe the orthodontic problem in your own words (what are YOUR main concerns?) _____

Who noticed the problem? Patient _____ Parent _____ Dentist _____

Any comments, questions, or suggestions _____

Medical History

Patient's physician(s) _____ Date last seen _____

Address _____ Phone _____

1. Please circle you PRESENT HEALTH: excellent good fair poor
 2. Has your health CHANGED in the last year? Yes No
 3. Have you been HOSPITALIZED in the last 5 years? Yes No
 4. Has a doctor TREATED or EXAMINED you for any condition in the last 3 years? Yes No
 5. Are you ALLERGIC to any drugs or other substances? Yes No
 6. Are you required to restrict your work or activities? Yes No
 7. Is your diet restricted or specially prescribed? Yes No
 8. Are you taking ANY MEDICATIONS regularly (even aspirin or antacids)? Yes No
- If "Yes", please list them with dosages: _____

PLEASE CIRCLE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM.

- | | | |
|---|---|---|
| 1. Heart trouble or murmur . . . Yes No | 17. Bronchitis Yes No | 34. Sinus trouble Yes No |
| 2. Rheumatic fever Yes No | 18. Frequent colds/
sore throat Yes No | 35. Artificial joints or valves . . . Yes No |
| 3. Heart surgery Yes No | 19. Emphysema Yes No | 36. Venereal disease Yes No |
| 4. Heart attack Yes No | 20. Birth Defects Yes No | 37. Thyroid/parathyroid
disorders Yes No |
| 5. High blood pressure Yes No | 21. Scarlet fever Yes No | 38. Cancer or tumors Yes No |
| 6. Low blood pressure Yes No | 22. Hives/rash Yes No | 39. Tuberculosis Yes No |
| 7. Chest pains Yes No | 23. Recurrent illness Yes No | 40. Speech impairment or
therapy Yes No |
| 8. Stroke Yes No | 24. Diabetes Yes No | 41. Hearing problem Yes No |
| 9. Immune system
problems, AIDS Yes No | 25. Kidney disease Yes No | 42. Emotional or
nervous problems Yes No |
| 10. Blood transfusion Yes No | 26. Liver disease Yes No | 43. Frequent headaches Yes No |
| 11. Excessive or
prolonged bleeding Yes No | 27. Epilepsy/seizures Yes No | 44. Smoker Yes No |
| 12. Blood disorder Yes No | 28. Fainting/dizzy spells Yes No | 45. Nervous/anxious Yes No |
| 13. Shortness of breath Yes No | 29. Ulcers Yes No | 46. Recent unintentional
weight changes Yes No |
| 14. Persistent cough Yes No | 30. Arthritis Yes No | 47. Psychiatric care Yes No |
| 15. Asthma/hay fever Yes No | 31. Glaucoma Yes No | |
| 16. Lung disease Yes No | 32. Allergies Yes No | |
| | 33. Ear pains or infections Yes No | |

IF FEMALE, ARE YOU:

Pregnant/Nursing Yes No On Birth Control Pills Yes No In or Past Menopause Yes No

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

COMMENTS: _____

1. _____ Date _____
Patient's Signature

4. _____ Date _____
Patient's Signature

2. _____ Date _____
Patient's Signature

5. _____ Date _____
Patient's Signature

3. _____ Date _____
Patient's Signature

6. _____ Date _____
Patient's Signature