DENTAL / MEDICAL HISTORY

Do you have speech problems? ☐ Yes ☐ No If Yes, explain _____

Do you presently have any of the following habits? ☐ Yes ☐ No

☐ Thumb sucking ☐ Finger sucking Chewing on ☐ pens ☐ pencils ☐ fingernails

Are your teeth sensitive to ☐ heat ☐ cold ☐ sweets

Have you ever had an injury to: (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Have you had any oral surgery? ☐ Yes ☐ No Please explain _____

Do your gums bleed? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you had any previous gum treatments or periodontal surgery? ☐ Yes ☐ No When? _____

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you had any previous orthodontic treatment? ☐ Yes ☐ No

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? ☐ Yes ☐ No

Frequent headaches	☐ Yes	☐ No
Head or neck pain	☐ Yes	☐ No
Difficulty opening or closing jaw	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Difficulty chewing	☐ Yes	☐ No
Jaw locks open or closed	☐ Yes	☐ No
Clenching or grinding teeth	☐ Yes	☐ No

Do you have a history of any major condition or illness (physical or mental)? ☐ Yes ☐ No Please list _____

Do you have any allergies or drug sensitivities? ☐ Yes ☐ No

Please list _____

Are you currently taking prescription drugs? ☐ Yes ☐ No

Please list _____

Do you have any other dental/medical condition or problem that is not mentioned above? ☐ Yes ☐ No Please explain _____

_____

Is there any other information that would be helpful to us? ☐ Yes ☐ No Please comment: _____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment.

Signature _____ Date _____

FOR DOCTOR'S USE ONLY

Angle Class: I ☐ II ☐ III ☐

Molar Relationship: R _____ | _____ L

Cuspid Relationship: R _____ | _____ L

Overjet Slight ☐ Moderate ☐ Severe ☐ _____ mm.

Overbite Slight ☐ Moderate ☐ Severe ☐ _____ mm.

Openbite Slight ☐ Moderate ☐ Severe ☐ _____ mm.

Max Arch: Normal ☐ Crowded ☐ Spaced ☐

Mand Arch: Normal ☐ Crowded ☐ Spaced ☐

Crossbite: Ant ☐ Post ☐ R ☐ L ☐

Arch Relationship: Normal ☐ Narrow Max ☐ Narrow Mand ☐ Wide Max ☐ Wide Mand ☐

Missing Teeth: R _____ | _____ L

Midline: Normal ☐ Max Shift to R ☐ L ☐ Mand Shift to R ☐ L ☐

Frenum: Normal ☐

Poss Surgery of: Max ☐ Mand ☐ Ling ☐

Hygiene: Good ☐ Fair ☐ Poor ☐

Facial Symmetry: Normal ☐ Asymmetry ☐

Facial Profile: Straight ☐ Convex ☐ Concave ☐

Extractions: Yes ☐ No ☐ Borderline ☐

Phase I ☐ Estimated treatment time _____

Phase II ☐ Estimated treatment time _____

Limited Tx ☐ Estimated treatment time _____

Notes: _____

_____

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Hygiene: Good ☐ Fair ☐ Poor ☐

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Notes: _____

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