

# ALIGN ORTHODONTICS

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date: \_\_\_\_\_

## DENTAL HISTORY

What do you not like about your teeth that brings you to see the orthodontist today?  
\_\_\_\_\_

Have you seen an orthodontist before? \_\_\_\_\_ If yes, who and when? \_\_\_\_\_

Your dentist's name: \_\_\_\_\_ Date of last exam/cleaning: \_\_\_\_\_

Are you aware of any dental work that is needed? \_\_\_\_\_

Any of your teeth, gums, or jaws hurting you at this time? ..... Y N

Have your wisdom teeth been removed?..... Y N If yes, how many? \_\_\_\_\_

Have any permanent teeth been injured by a fall or a blow? ..... Y N

Have you ever experienced pain or tenderness in the jaw joint? ..... Y N

How many times a week do you floss? \_\_\_\_\_ How many times a day do you brush? \_\_\_\_\_

Have you ever experienced:

Popping/clicking/pain of jaw	Y	N	Gum bleeding	Y	N
Gum disease	Y	N	Ear infections	Y	N
Teeth grinding or clenching	Y	N	Thumb sucking	Y	N
Missing/extra permanent teeth	Y	N	Mouth breathing	Y	N
Tongue thrusting	Y	N	Other : _____		

## MEDICAL HISTORY

Name of your physician: \_\_\_\_\_ Phone/Address: \_\_\_\_\_

Date of last visit? \_\_\_\_\_ Reason? \_\_\_\_\_

Are you currently under the care of a doctor? Y N Reason? \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

Allergies to any medicine, latex, metals, or plastics: \_\_\_\_\_

Are / were you a smoker? Y N For how long? \_\_\_\_\_ Years @ \_\_\_\_\_ packs/day

For Women: Taking birth control pills? Y N Pregnant? Y N Week #: \_\_\_\_\_

Please check any of the following for which you have been diagnosed and/or treated:

Abnormal Bleeding	Y	N	Glaucoma	Y	N
ADD / ADHD	Y	N	Headaches	Y	N
Anemia	Y	N	Heart Trouble/Murmur	Y	N
Arthritis	Y	N	Hepatitis	Y	N
Asthma	Y	N	High Blood Pressure	Y	N
Bone Disorders	Y	N	HIV/AIDS	Y	N
Blood Transfusion	Y	N	Neck Pain	Y	N
Diabetes	Y	N	Rheumatic Fever	Y	N
Drug/Alcohol Abuse	Y	N	Thyroid Disorders	Y	N
Epilepsy	Y	N	Tuberculosis	Y	N
Fever Blister	Y	N	Other: _____		

**I understand that all the information given above is true and will be used for record and treatment evaluation.**

Signature (Parent's signature if under 18) \_\_\_\_\_ Date: \_\_\_\_\_