align braces & kids' dental

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? _____

Name of your dentist: _____ Date of last exam/cleaning: _____

Does your dentist still need to see you for dental or gum treatment? _____

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: _____

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 Issues	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: _____