

Medical / Dental Information

Patient Name First _____ Last _____

Dental Information

What is your main reason for seeing an orthodontist? (check all that apply)

- | | | | | |
|---|-----------------------------------|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Crowding | <input type="checkbox"/> Spacing | <input type="checkbox"/> Missing or extra teeth | <input type="checkbox"/> Overbite |
| <input type="checkbox"/> Don't like smile | <input type="checkbox"/> Bad bite | <input type="checkbox"/> Crossbite | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Other _____ |

Please explain _____

Are you concerned about the appearance of teeth? No Yes

Are you frightened or anxious about treatment? No Yes

Would you mind wearing braces if necessary? No Yes

Invisible braces? No Yes

What aspect of orthodontic treatment are you most concerned with?

- Esthetics Discomfort Cost Quality Time

Any missing or extra teeth? _____

Any sores, lumps or irritated areas in the mouth? No Yes

Any previous orthodontic treatment? No Yes

When? _____

Have other members of the family had orthodontic treatment?

No Yes If so, whom? _____

Are they satisfied with the results? No Yes

About patient's home care

Please rate oral hygiene Good Fair Poor

Brush teeth daily? No Yes

Floss teeth? No Yes

How often? _____

Any previous treatment for? TMJ Gum Disease

By Whom? _____

Why? _____

Is this a second opinion? No Yes

Who was the first? _____

Why? _____

Any injuries to face, head, mouth or teeth? No Yes

When? _____

Pain in or near ears? No Yes

When? _____

Headaches, facial pain or jaw joint problems? No Yes

If so, please explain _____

Are there any speech problems? No Yes

Please explain _____

Any history of these habits?

Mouth Breathing Nail/Lip biting Leaning on chin or face

Grinding of teeth Thumb sucking Snoring

Other _____

General Dentist – Dr _____ Date of last visit _____

Any other information that would be helpful? _____

Continued on back

Medical Information

Overall medical health Good Fair Poor

Smoker Non Smoker

Is there a tendency for Ear infections Colds Sore throats

Any history of:

Asthma No Yes

Diabetes No Yes

Cold sores/Herpes No Yes

Hepatitis No Yes

Blood disease No Yes

Epilepsy No Yes

Anemia No Yes

Rheumatic Fever No Yes

Heart disease No Yes

Allergies No Yes

Bone Disorders No Yes

AIDS/HIV No Yes

Any other medical problems we should be aware of? _____

Is pre-medication needed before dental treatment? No Yes Uncertain If so why? _____

Have tonsils and adenoids been removed? No Yes If so, when? _____

If adolescent female, has menstrual cycle started? No Yes If so, approximately when? _____

List any drugs or medications being taken.

List any allergies or drug sensitivities

Physician - Dr. _____ Date of last visit _____

I understand that the information that 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.

Signature _____ Date _____

PRIVACY POLICY

I, _____, acknowledge that I Have reviewed the Privacy Policy Notice for The Best Braces
(Parent / Guardian name - if patient is under 18)

Signature _____ Date _____

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for Parent / Guardian / Patient's refusal to sign _____

Privacy director's Signature _____ Date _____