

PERSONAL RECORD

Patient's Name _____ Sex _____
Birthdate _____ Age _____ School _____ Grade _____
Your reason for seeing us today? _____
Family Physician _____
Other family members treated by our practice _____

DENTAL AND HEALTH HISTORY

Other orthodontic consult or treatment?	YES ___	NO ___	WHEN? _____
Any injuries/accidents to face or teeth?	YES ___	NO ___	DESCRIBE? _____
Difficulty chewing?	YES ___	NO ___	
Difficulty swallowing?	YES ___	NO ___	
Difficulty speaking?	YES ___	NO ___	
Did/does patient suck thumb or fingers?	YES ___	NO ___	
Mouth breathing?	YES ___	NO ___	
Have tonsils or adenoids been removed?	YES ___	NO ___	
Snoring at night?	YES ___	NO ___	
Are you on any medication?	YES ___	NO ___	DESCRIBE? _____
Abnormal bleeding?	YES ___	NO ___	
Allergies to medication?	YES ___	NO ___	DESCRIBE? _____
Allergic to latex?	YES ___	NO ___	
Arthritis?	YES ___	NO ___	
Asthma?	YES ___	NO ___	
Blood transfusion?	YES ___	NO ___	
Cancer?	YES ___	NO ___	
Chronic ear Infection?	YES ___	NO ___	
Diabetes?	YES ___	NO ___	
Dizziness?	YES ___	NO ___	
Frequent headaches?	YES ___	NO ___	HOW OFTEN? _____
Frequent neck or backaches?	YES ___	NO ___	DESCRIBE? _____
Grinding Teeth at night?	YES ___	NO ___	
Heart murmur?	YES ___	NO ___	PRE-MEDICATION? _____
Hepatitis?	YES ___	NO ___	
HIV / AIDS?	YES ___	NO ___	
Popping/clicking of the jaw joints?	YES ___	NO ___	DESCRIBE? _____
Rheumatic/Scarlet Fever?	YES ___	NO ___	
Ringing in the ears?	YES ___	NO ___	
Tuberculosis?	YES ___	NO ___	
Smoke or use nicotine products?	YES ___	NO ___	
Any gum tissue concerns or previous treatments?	YES ___	NO ___	

Is there any other condition or problem that you think we should know about? PLEASE DESCRIBE _____

Orthodontic Insurance?	YES ___	NO ___
Insurance Co. Name	_____	
Insurance Co. Address	_____	
Insurance Co. Phone	_____	
Insured's Employer	Social Security #	_____

Signature _____ Date _____