

Date _____

Patient Name _____

I. Subjective Concerns

A. What are the patient's or parent's main concerns regarding the jaw and teeth

- Dentist Recommended Seeing an Orthodontist
- Crowding of Upper Teeth
- Crowding of Lower Teeth
- "Buck" Teeth/Overjet
- Overbite
- Underbite
- Spaces
- Bad Bite
- Crossbite
- Grinding Teeth
- Gummy Smile
- Impacted Tooth/Teeth
- Improper Tooth Position
- Irregular Facial Proportions
- Irregular Shaped Tooth/Teeth
- Missing Tooth/Teeth
- Mouth Too Small
- Open Bite
- Prominent Lower Jaw (too "strong")
- Protrusion of Teeth
- Recessive Lower Jaw (too "weak")
- Rotations
- Small Teeth
- Thumb/Finger Habit
- Other _____

B. Family Members with similar problems

- Father
- Sister
- Mother
- OTHER _____
- Brother

C. Other Pertinent Information

(Has the patient ever had a history of the following?):

- Difficulty Chewing
- Difficulty Swallowing
- Finger/Thumb Sucking
- Grinding Teeth
- Headaches
- Lip Biting
- Mouth Breathing
- Pain in Jaw Joint
- Snoring
- Speech Problems
- Tongue Thrusting
- Tonsillitis
- OTHER

II. Medical History

A. Medications (current medications taken by the patient):

B. Allergies to Medications/Food (the patient displays an allergic response to):

- Jewelry/Metals
- Antibiotics (List) _____
- Latex
- Aspirin
- OTHER _____
- Codeine

C. Has the patient ever had any of the following conditions?

- Allergies
- Hospitalized for Any Reason
- AIDS/HIV (Circle)
- Heart Murmur
- Asthma
- Pacemaker
- Autoimmune Disorder
- Psychiatric Problems
- Blood Disease
- Radiation Treatment
- Bone Disorders
- Rheumatic Fever
- Cancer
- Ringing of Ears
- Diabetes
- Seizures
- Dizziness
- Sinus Problems
- Endocrine Problems
- Thyroid Problems
- Epilepsy
- Trauma (to face, teeth, jaws, or head)
- Glaucoma
- Ulcers
- Hearing Disorders

D. Are there any medical, dental, surgical or psychological problems not covered above? NO / YES If yes, please explain

III. Patient's or Parent's attitude toward dental care and orthodontic treatment.

Patient's general dentist _____

Town, State _____

Last visit for cleaning/exam _____

Any work still needing to be completed? YES / NO

A. Regular dental check ups: Twice a year Once a year
 Only if necessary None

B. Patient's attitude towards orthodontic treatment:

C. Has the patient ever had any unusual dental experiences?

D. Has the patient ever had a previous orthodontic consultation/treatment? No / YES If yes, Name of Doctor

E. Why are you seeking this consultation?

To the best of my knowledge, all the proceeding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

Patient/Responsible Party's Signature

Date