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ORTHODONTIC EXAMINATION RECORD

Patient Name: ________________________ **Date:** _________ Preferred Name:_______________________________

Date of Birth: ____________ Age: ______ Sports/Hobbies/Interests: _______________________________________

Mother's Name: _______________________ Father's Name: __________________________ Divorced? Y N

Billing Party: ___________________________ Occupation: ____

Address: ______________________________ City: ___________________________ Zip Code: _____________

Home Phone: ___________________________ Work Phone: __________________ Cell Phone: ___________________

E-mail:_______________________________ Appointment confirmations – send by? Email Text

Patient's Dentist: ______________________ Referred By: ________________________

Dental Insurance Company: ____ Orthodontic Benefits? Yes No

MEDICAL HISTORY

1. Is the patient in good health? Yes No
2. Does the patient have any history of major illness? Yes No
   If yes, please explain. ____
3. Circle any of the following medical conditions that exist or have existed for the patient:

Diabetes	Birth Defects	Heart Disorders	Bone Disorders	Tonsil/Adenoid Condition
Pneumonia	Tuberculosis	Endocrine Disorders	Kidney Disorders	Mental Health Condition
Cancer	Anemia	Bleeding Disorders	Neurological Disorders	History of Eating Disorder
Rheumatic Fever	Epilepsy	Liver Disorders	Hepatitis B or HIV	Neurological Disorders
Arthritis	Asthma	Fainting/Dizziness	Immune Disorders	High/Low Blood Pressure

4. Does the patient require antibiotic pre-medication prior to dental procedures? Yes No
5. Does the patient have frequent colds, sore throats, or ear infections? Yes No
6. Does the patient chew or smoke tobacco? Yes No
7. Has the patient reached puberty? Yes No
8. List any allergies or drug sensitivities: ____
9. List any medications currently being taken: ____
10. Is there any reason X-rays should not be taken? Yes No

DENTAL HISTORY

1. Has there been any injury to the face, mouth, or teeth? Yes No
2. Has the patient ever sucked their thumb or fingers? Yes No
   If yes, until what age?________
3. Has the patient ever had oral habits such as lip biting or tongue thrusting? Yes No
4. Is the patient a mouth breather? Yes No
5. Does the patient have any speech problems? Yes No
6. Has the patient had any clicking or discomfort in the jaws? Yes No
7. Does the patient clench or grind his/her teeth? Yes No
8. Has an orthodontist been consulted previously? Yes No
9. Has either parent or other children had orthodontic treatment? Yes No
10. Is there a family history of jaw size imbalance (underbite or horizontal overbite)? Yes No
11. The patient's last dental visit was: _________________. Were any X-rays taken? Yes No

PATIENT PROFILE

1. Does the patient follow directions well? Yes No
2. Does the patient brush his/her teeth conscientiously? Yes No
3. Does the patient have learning disabilities or need extra help with instructions? Yes No
4. Is the patient sensitive or self-conscious about their teeth? Yes No

Signed____ **Relationship to Patient**_______________________