Medical / Dental Information

Patient Name First _____ Last _____

Dental Information

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

☐ Crooked teeth ☐ Crowding ☐ Spacing ☐ Missing or extra teeth ☐ Overbite

☐ Don't like smile ☐ Bad bite ☐ Crossbite ☐ Jaw pain ☐ 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

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 _____

About patient's home care

Please rate oral hygiene ☐ Good ☐ Fair ☐ Poor

Brush teeth daily? ☐ No ☐ Yes

Floss teeth? ☐ No ☐ Yes

How often? _____

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 Drs. Shaw & Jane

(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 _____

Clear Form