

Computer ID # _____

Date _____



Name _____ Birthdate _____ Age _____ Sex M F
 Address _____ Home Phone _____
 City _____ State _____ Zip _____
 Occupation & Bus. address _____ Bus. Telephone _____
 Cell Phone _____ Email _____ Marital Status: S M W D
 Spouse's Name _____ Spouse's Occupation _____
 Bus. Address _____ Bus. Telephone _____
 Person Financially Responsible _____ Relationship _____
 Address (if different) _____ SS# _____ DL# _____
 Referred by _____ Dentist _____

ORTHODONTIC INFORMATION

Reason For Orthodontic Consultation _____
 Previous Treatment - Patient Or Others In Family: Yes _____ No _____
 What Do You Consider To Be The Main Benefits Of Orthodontic Correction?
 Cosmetic _____ Functional _____ Psychological/Emotional _____ Other _____
 Are you Self-Conscious Of your Teeth? Yes _____ No _____
 Attitude Toward Orthodontic Treatment: Enthusiastic _____ Indifferent _____ Resentful _____

MEDICAL HISTORY

Present State of Health Excellent _____ Good _____ Fair _____ Poor _____
 Currently Under Physician's Care Yes _____ No _____ Why? _____
 Currently Taking Medication Yes _____ No _____ Why? _____
 Do You Have A History Of:
 Accidents Hearing Problems Bleeding Disorders Tuberculosis Headaches
 Emotional Disorders Facial Operations Allergies Hospitalization Glaucoma
 Speech Problem Rheumatic Fever Hepatitis Heart Trouble Cancer
 Accidents to Face Latex (Rubber) Sensitivity Mitral Valve Prolapse Artificial Joints
 H.I.V. Positive (AIDS)

DENTAL HISTORY

Date of Last Dental Exam _____ Have Full Mouth X-Rays Been Taken? Yes _____ No _____
 Oral Hygiene Habits: Do You Floss regularly? _____ Do Your Gums Bleed? _____ Snoring _____
 Do You Clench Your Teeth? _____ Do You Grind Your Teeth? _____ Mouth Breathing _____
 Is There Any Hereditary Background (familial tendency) Which Might Contribute To This Orthodontic Problem? _____

Signed _____ Date _____