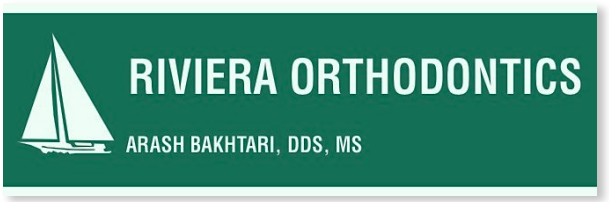

Patient's Clinical History/Family Information *(please complete in ink)*

Name _____
LAST FIRST M.I.

Date of Birth_____/_____/_____ Age_____ Sex_____ SSN: ____ - ___ - ____
MM DD YY

Address _____
Number Street Suite/Apt. City ZIP

Tel. (____)_____ Cell Phone (____) _____

Mother's Name_____ Date of Birth_____/_____/____
LAST FIRST M.I. MM DD YY

Employed by _____ Occupation_____

Employer Address _____

Email Address: _____

Best Telephone Number To Contact You During Business Hours (___) _____

Mother's Marital Status:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Father's Name_____ Date of Birth_____/_____/_____
LAST FIRST M.I. MM DD YY

Employed by _____ Occupation_____

Employer Address _____

Email Address: _____

Best Telephone Number To Contact You During Business Hours (___) _____

Father's Marital Status:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Family Dentist_____

Family Physician_____

Whom May We Thank For Referring You To Our Office? _____

Does Mother have Orthodontic Insurance? ❑ Yes ❑ No Name of Insurance Company_____

Does Father have Orthodontic Insurance? ❑ Yes ❑ No Name of Insurance Company_____

If responsible party is other than the patient's parents, please give information: ❑ Not Applicable

Name_____ Relationship to Patient_____

Address _____ Tel.# (_____)_____

Does He or She have Orthodontic Insurance? ❑ Yes ❑ No Insurance Company_____

MEDICAL HISTORY:

Have you had or do you have any of the following?

	YES	NO		YES	NO
Rheumatic Fever	❑	❑	Persistent Headaches	❑	❑
Heart Murmur	❑	❑	Neck Pains	❑	❑
High Blood Pressure	❑	❑	Nerve or Brain Disease	❑	❑
Heart Attack/Stroke	❑	❑	Migraine	❑	❑
Blood Vessel Disease	❑	❑	Epilepsy	❑	❑
Blood Disorder	❑	❑	Autism/Asperger's Syndrome	❑	❑
AIDS/HIV Infection	❑	❑	ADD/ADHD	❑	❑
Hepatitis	❑	❑	Mental Health Problems	❑	❑
Diabetes	❑	❑	Bone Disorders	❑	❑
Ulcers	❑	❑	Arthritis	❑	❑
Herpes (Any Type)	❑	❑	Artificial Joints	❑	❑
Psoriasis	❑	❑	Sleep Apnea	❑	❑
Cancer	❑	❑	Ear Disorders	❑	❑
Sinus Infection	❑	❑	Swollen Glands	❑	❑
Allergies	❑	❑	Other _____		

Comments_____

_____

Please List Any Other Significant Information About the Patient's Medical History:

_____

_____

YES NO

❑ ❑ Is the patient under a physician's care at present? If yes, reason_____

❑ ❑ Is the patient presently, or have you ever been, under the care of a psychiatrist or psychologist? If yes, please describe_____

❑ ❑ Is the patient currently taking any medication? If yes, describe_____

❑ ❑ Is the patient allergic to any medications? (E.g.: aspirin, penicillin, etc.) If yes, what?_____

❑ ❑ Has the patient ever had any general anesthesia? When?_____

DENTAL HISTORY

YES NO

❑ ❑ Do any of the patient's teeth hurt?

If yes, upper right ❑ upper left ❑ lower right ❑ lower left ❑

YES NO

❑ ❑ Have any wisdom teeth been removed? How many?_____

❑ ❑ Has the patient had treatment for periodontal disease (gum disease)?

If yes, describe _____

❑ ❑ Has the patient ever had any previous orthodontic treatment (braces)?

If yes, when _____ Length of Treatment? _____

If yes, doctor's name and address_____

❑ ❑ Have there been any injuries to your child's mouth or teeth?

If yes, describe _____

❑ ❑ Has the patient ever had any injury in the head and neck area?

If yes, describe _____

❑ ❑ Has the patient ever fallen and bumped his/her chin, or received a blow to the jaws?

If yes, describe_____

❑ ❑ Has the patient ever had any surgery in the head and neck area?

If yes, describe_____

❑ ❑ Does the patient clench or grind their teeth? If yes, while sleeping ❑ under stress ❑

other ❑

❑ ❑ Do the patient's jaw muscles ever feel tired? If yes, when_____

❑ ❑ Does the patient ever notice soreness, tightness or pain in the muscles around the jaw and face?

If yes, describe _____

YES NO

❑ ❑ Does it hurt to chew? If yes, where does it hurt?_____

❑ ❑ Do you hear clicking (popping) or grating sounds in the jaw joints? If yes, please describe:

	RIGHT	LEFT	SINCE WHEN	DURING WHAT ACTIVITY
❑ Clicking	❑	❑	_____	_____
❑ Grating	❑	❑	_____	_____

Did these joint sounds begin gradually or suddenly? Gradually ❑ Suddenly ❑

❑ ❑ Was there some specific event that started the joint sounds?
If yes, describe _____

❑ ❑ Has the patient ever experienced difficulty in opening or closing your jaws?
If yes, describe _____

❑ ❑ Have the jaws ever "locked" closed? If yes, describe _____

❑ ❑ Have the jaws ever "locked" wide open? If yes, describe _____

❑ ❑ Does the patient have pain in the jaw joints? If yes, right ❑ left ❑

Since when? _____

Did your pain start gradually or suddenly? Gradually ❑ Suddenly ❑

What increases the pain?_____ What decreases the pain? _____

Do you have any of the following habits?

YES	NO	
❑	❑	Finger/Thumb sucking
❑	❑	Lip Biting
❑	❑	Nail Biting
❑	❑	Gum Chewing
❑	❑	Ice Chewing
❑	❑	Pen/Pencil Chewing

GROWTH AND DEVELOPMENT

YES	NO	
❑	❑	Has patient reached adolescent growth? _____
❑	❑	Girls – Has monthly cycle started yet? If so, when _____
❑	❑	Boys – Has voice changed yet? If so, when_____
❑	❑	Are there any learning disabilities? If yes, please explain_____
❑	❑	Are there other children in the family?_____
		Names and Ages_____
❑	❑	Has any other member of the family had orthodontic treatment?
		Patient's present height_____
		Father's height_____ Mother's height_____

Please describe why you sought this consultation. What is your main concern?

_____

_____

Have you ever been treated for this problem before? If yes, please describe diagnosis and treatment.

_____

_____

Has any other member of the family had orthodontic treatment? Yes ____ No _____

Are there any other concerns not covered in this clinical history form? _____

_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

PATIENT OR PARENT'S SIGNATURE DATE

_____ _____

DOCTOR'S SIGNATURE DATE

Member American Association of Orthodontists

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