Dental History

Name of Family Dentist: _____ Date of last dental visit: _____

How many times a day do you ***BRUSH***? ☐0 ☐1 ☐2 ☐3+ How many times a day do you ***FLOSS***? ☐0 ☐1 ☐2+

- Has this patient been examined by another orthodontist? ☐No, If ☐Yes, Date: _____, Name of orthodontist _____
- Has this patient ever had *orthodontic treatment* (braces)? ☐No, If ☐Yes, Date: _____, Name of dentist _____
- Has this patient been treated for TMJ problems? ☐No, If ☐Yes, Date: _____, Name of dentist _____
- Has this patient been treated for *gum* disease? ☐No, If ☐Yes, What kind of treatment? _____
- Has this patient had *root canal* treatment? ☐No, If ☐Yes, Which Teeth? _____
- Has this patient had *other* dental specialist treatment? ☐No, If ☐Yes, What? _____

- Does this patient have any of the oral habits? ☐No, If ☐Yes, ☐Thumb sucking ☐Finger sucking ☐Lip Biting ☐Tongue Thrusting ☐Speech problems ☐Mouth Breathing
  Comments? _____

Habit Alert? ☐No _____

- Does this patient have any *TMJ* (jaw joint) *Symptoms*? ☐No, If ☐Yes, ☐Grinding ☐Clenching ☐Jaw Joint Noises ☐Headaches/Neckaches ☐Jaw Joint Pain ☐Facial or Ear Pain ☐Locking or difficulty moving of Jaws ☐Dental/Facial Trauma ☐Arthritis
  Comments? _____

TMJ Alert? ☐No _____

- Does this patient have any *Missing Permanent Teeth?* ☐No, If ☐Yes, Comment: _____
- Does this patient have any *Extra Permanent Teeth?* ☐No, If ☐Yes, Comment: _____
- Does this patient typically have *bleeding gums?* ☐No, If ☐Yes, Comment: _____
- Does this patient have *sores, lumps or irritated tissue* in the mouth? ☐No, If ☐Yes, Comment: _____
- Has this patient had any *injuries* to his/her teeth? ☐No, If ☐Yes, @ Age: _____ ☐Chipped ☐Broken ☐Lost _____
- Has this patient had any *injuries* to his/her face or jaws or mouth? ☐No, If ☐Yes, @ Age: _____ Comment: _____
- Does this patient have or been informed of any *Speech Problems?* ☐No, If ☐Yes, Comment: _____
- Are there any other comments about this patient's dental history? ☐No, If ☐Yes, Comment: _____

Patient and Family Concerns:

- Is this patient anxious about having orthodontic treatment? ☐No, If ☐Yes, Comment: _____
- What are this patient's concerns about orthodontic treatment? ☐ Appearance of Teeth ☐ Oral Function ☐ Crowding/Spacing ☐ Protrusion ☐ Other concerns or comments: _____
- Does the family dentist have any concerns about this treatment? ☐ No, If ☐Yes, Comment: _____
- Do other family members have any concerns about this treatment? ☐ No, If ☐Yes, Comment: _____

Family History of orthodontic treatment:

- *Mother:* ☐No, If ☐Yes: Dentist _____ Were you satisfied with the results? ☐Yes, ☐No _____
- *Father:* ☐No, If ☐Yes: Dentist _____ Were you satisfied with the results? ☐Yes, ☐No _____
- *Sister:* ☐No, If ☐Yes: Dentist _____ Were you satisfied with the results? ☐Yes, ☐No _____
- *Brother:* ☐No, If ☐Yes: Dentist _____ Were you satisfied with the results? ☐Yes, ☐No _____

Comments: _____

☺ If your dentist has taken new **full mouth** or **panoramic x-rays** in the past six months, *please bring them with you to the exam.*

☺ If you have had **orthodontic records** taken in the past six months, *please bring them with you to the exam.*

☺ If you are currently wearing an **orthodontic appliance or TMJ Splint**, *please bring it with you to the exam.*

☺ Is there any other medical or dental condition that we should know about? ☐ No, If ☐Yes, Comment _____

I the undersigned have completed this medical and dental health history and certify that the preceding information is true and correct. This practice cannot be held responsible for any problems arising out of inadequate information not disclosed here. If there are any future changes in this information, I will inform this practice of these changes.

Signature of *person filling out this history:* _____ Date completed/signed: _____

Signature of *TC* who reviewed this history: _____ Date reviewed/signed: _____

Signature of *DOCTOR* who reviewed entire history: _____ Date reviewed/signed: _____