LOWE ORTHODONTICS

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Patients Clinical History/Family Information

(please complete in ink)

Patient's Name ____Age ____ Sex ___ Date of Birth _______
Last First M.I.

Address ____ ____________Tel.# ____________________
Street City Zip
School____________________ Grade___
Best Telephone Number to call for appointments (During Business Hours) ____________________________________

Patient's Family Dentist __________________________ Patient's Family Physician ________________________

Whom may we thank for referring you to our office? ____

- -

Father's Name ____ Father's S.S#____________________
Last First M.I (For accounting purposes only)
Martial Status: ___Single ___Married ___ Separated __ Divorced __Widowed ___Remarried
Home Address____Tel. # ______________________________

Employed by___________________ Occupation______________ Position ____________________________

Office Address ____Tel. # ____________________________
Does Father have Orthodontic Insurance ? __Yes ___No Name of Ins. Co.________________________________
Does Father have Medical Insurance? ____Yes ____ No Name of Ins. Co.________________________________
Date of Birth (For insurance purposes only) ____

- -

Mother's Name ____ Mother's S.S#____________________
Last First M.I (For accounting purposes only)
Martial Status: ___Single ___Married ___ Separated __ Divorced __Widowed ___Remarried
Home Address____Tel. # ______________________________

Employed by___________________ Occupation______________ Position ____________________________

Office Address ____Tel. # ____________________________
Does Mother have Orthodontic Insurance ? __Yes ___No Name of Ins. Co.________________________________
Does Mother have Medical Insurance? ____Yes ____ No Name of Ins. Co.________________________________
Date of Birth (For insurance purposes only) ____

* *If responsible party is other than the patient, please give information:* __ Not Applicable
Name______________________________ S.S. #_____________________ Relationship to patient________________
Date of Birth__________
Address____ Tel. #______________________
Does Responsible Party have Orthodontic Insurance? ____Yes ___No Name of Ins. Co.__________________________
Does Responsible Party have Medical Insurance? ____Yes ___No Name of Ins. Co.__________________________
Responsible Party's EMAIL ADDRESS____

MEDICAL HISTORY:
Has patient had or does patient have any of the following?

	Yes/ No			Yes/ No	
Diabetes	O	O			
Rheumatic Fever	O	O	Allergies	O	O
Heart Murmur	O	O	Latex Allergies	O	O
High Blood Pressure	O	O	Nerve or Brain Disease	O	O
Heart Attack/Stroke	O	O	Migraine	O	O
Blood Vessel Disease	O	O	Epilepsy	O	O
Blood Disorder	O	O	Mental Health	O	O
AIDS/HIV Infection	O	O	Bone Disorders	O	O
Hepatitis	O	O	Arthritis (any type)	O	O
Ulcers	O	O	Gout	O	O
Herpes	O	O	Ear Disorder	O	O
Psoriasis	O	O	Sinus Infection	O	O
Cancer	O	O	Glands	O	O
Persistent Headaches	O	O	Neck Pains	O	O

Comments _____
Please list any other significant information about the patient's medical history:
_____
_____

Yes/ No

O O Is patient under a physician's care at present? If yes, reason _____

O O Is patient presently, or ever been, under the care of a psychiatrist or psychologist?
If yes, describe _____

O O Is patient currently taking any medication? If yes, describe _____
_____

O O Is the patient allergic to any medications? (eg: asprin, penicillin, etc.) If yes, describe:_____

O O Has patient ever had any general anesthesia? When? _____

Yes/ No

O O Do any of your teeth hurt? If yes, upper right upper left lower right lower left

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

O O Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe_____

O O Have you ever had any previous orthodontic treatment (braces)? If yes, when _____
If yes, doctor's name and address _____

O O Have there been any injuries to the mouth or teeth? If yes, describe_____

O O Have you ever had any injury in the head and neck area? If yes, describe_____

O O Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe_____

O O Have you ever had any surgery in the head and neck area? If Yes, describe _____

O O Do you clench or grind your teeth? If yes, while sleeping Under stress other_____

O O Do your jaw muscles ever feel tired? If yes when_____

O O Do you ever notice soreness, tightness or pain in the muscles around the jaws and face?
If yes, describe _____

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

O O Do you hear clicking (popping) or grating sounds in your 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

O O Was there some specific event that started the joint sounds? If yes, describe_____

O O Have you ever experienced difficulty in opening or closing your jaws? If yes, describe_____

O O Have your jaws ever "locked" closed? If yes, describe _____

O O Have your jaws ever "locked" wide open? If yes, describe_____

Yes/ No

O O Do you have pain in your jaw joints? If yes, right □ Left □ Since when? _____
Did your pain start gradually or suddenly? Gradually □ Suddenly □
During what activity? _____ Describe nature of pain _____
What increases the pain ? _____ What decreases the pain? _____

Do you have any of the following habits?

Yes/ No

O O Finger/Thumbsucking
O O Lip Biting
O O Nail Biting
O O Gum Chewing
O O Ice Chewing

GROWTH AND DEVELOPMENT:

Yes/No

O O Has patient reached adolescent growth?_____
O O Girls– Has monthly cycle started yet? If so, when_____
O O Boys– Has voice changed yet? If so, when_____
O O Is the patient adopted? Does the patient know? Yes No
O O Are there any learning disabilities? If yes, explain_____
Patient height_____ Expected height of patient_____
Father's height_____ Mother's height_____
O O Are there other children in the family?
Names and ages_____
O O Has any other member of the family had orthodontic treatment?
O O Has any other member of the family been a patient of this office? Name_____
Please describe why you sought this consultation_____
O O Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment_____

Any information you can give me concerning the patient will be appreciated. The more I know about each patient, the more help I can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies: _____
_____
_____

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 the patient's clinical history , I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____
(Parent/Guardian's Signature) Date

Doctor's Notes _____
_____
_____
_____
_____
_____
_____
_____

_____ _____
(Doctor's Signature) Date

Dr.'s Preliminary Diagnosis
(For Dr.'s use only)

CC: _____

Dentition Stage

☐ Primary ☐Early Mixed ☐Middle mixed ☐ Late mixed ☐ Permanent

Angle Class

Right Molar	Left Molar
☐ I	☐ I
☐ II	☐ II
☐ III	☐ III

Overbite

☐ Normal ☐ Mild deep ☐ Moderate deep ☐ Severe deep ☐ Very Severe deep

☐ E/E ☐ Mild Open ☐ Moderate open ☐ Severe Open

Overjet

☐ Normal ☐Mild ☐ Moderate ☐Severe ☐Complete Ant. X-bite

☐ Partial Ant. X-bite
Teeth Involved 3 2 1 | 1 2 3

Crowding

Maxilla	Mandible
☐ None	☐ None
☐ Mild	☐ Mild
☐ Moderate	☐ Moderate
☐ Severe	☐ Severe
☐ Spacing	☐ Spacing

Posterior X-Bite

☐ None ☐ Right ☐ Left ☐ Single Tooth: Teeth involved 6 5 4 3 2 1 | 1 2 3 4 5 6

☐ Buccal x-bite: Teeth Involved 6 5 4 3 2 1 | 1 2 3 4 5 6

Missing Teeth

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Notes _____

_____

_____

_____

_____