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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

Best Telephone Number to call for appointments (During Business Hours) _____

Fax Number _____ Email Address _____

Employed by _____ Occupation _____ Position _____

Office Address _____ Tel# _____

Patient's SS# _____ (for accounting purposes only)

Patient's Family Dentist _____ Patient's Family Physician _____

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

Do you have Orthodontic Dental Insurance? Yes No
 Name of Ins. Co. _____ Member ID# _____

Do you have Medical Insurance? Yes No Name of Ins. Co. _____

Marital Status: Single Married Separated Divorced Widowed Remarried
 Spouse's Name: _____

*If responsible party is other than the patient, please give information: ___ Not Applicable

Name _____ Relationship to patient _____
 Address _____ Tel# _____
 SS# _____ (for accounting purposed only)
 Employed by _____ Occupation _____ Position _____
 Office Address _____ Tel# _____
 Does Responsible Party hold your Orthodontic Insurance? ___ Yes ___ No Resp. party DOB: _____
 Name of Ins. Co. _____ Tel# _____

MEDICAL HISTORY:

Has patient had or does patient have any of the following?

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

Comments: _____

Please list any other significant information about the patients medical history: _____

Yes/ No

- Is patient under a physician's care at present? If yes, reason _____
- Is patient presently, or ever been, under the care of a psychiatrist or psychologist?
-If yes, describe _____
- Is patient currently taking any medication? If yes, describe _____
- Is the patient allergic to any medications? (eg: aspirin, penicillin, etc.) If yes, describe: _____
- Has patient ever had any general anesthesia? When? _____
- Do any of your teeth hurt? If yes, upper right upper left lower right lower left
- Have any wisdom teeth been removed? How many? _____
- Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe _____
- Have you ever had any previous orthodontic treatment (braces)? If yes, when _____
-If yes, doctor's name and address _____
- Have there been any injuries to the mouth or teeth? If yes, describe _____
- Have you ever had any injury in the head and neck area? If yes, describe _____
- Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe _____
- Have you ever had any surgery in the head and neck area? If Yes, describe _____
- Do you clench or grind your teeth? If yes, while sleeping Under stress other
- Do your jaw muscles ever feel tired? If yes when _____
- Do you ever notice soreness, tightness or pain in the muscles around the jaws and face?
-If yes, describe _____
- Does it hurt to chew? If yes, where does it hurt? _____
- Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
<input type="checkbox"/> Clicking:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Grating:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Did these joint sounds begin gradually or suddenly? Gradually Suddenly
- Was there some specific event that started the joint sounds? If yes, describe _____
- Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____
- Have your jaws ever "locked" closed? If yes, describe _____
- Have your jaws ever "locked" wide open? If yes, describe _____
- 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

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

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 & 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.

(Patient 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

- | | |
|------------------------------|------------------------------|
| <input type="checkbox"/> I | <input type="checkbox"/> I |
| <input type="checkbox"/> II | <input type="checkbox"/> II |
| <input type="checkbox"/> III | <input type="checkbox"/> III |

Overbite:

- | | | | | |
|---------------------------------|------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Mild deep | <input type="checkbox"/> Moderate deep | <input type="checkbox"/> Severe deep | <input type="checkbox"/> Very Severe deep |
| <input type="checkbox"/> E/E | <input type="checkbox"/> Mild Open | <input type="checkbox"/> Moderate open | <input type="checkbox"/> Severe Open | |

Overjet:

- Normal
 Mild
 Moderate
 Severe
 Complete Ant. X-bite (underbite)

Partial Ant. X-bite :

Teeth Involved : 3 2 1 | 1 2 3

Crowding:

-Maxilla

-Mandible

- | | |
|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> None |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Mild |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Severe | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Spacing | <input type="checkbox"/> Spacing |

Dental Mobility:

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: _____
