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) _____

* Please list the responsible party for the above patient:

Name_____ S.S. #_____ Relationship to patient_____

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	Neck Pains	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			

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? _____

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

☐ ○ 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

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_____

○ ○ Is the patient adopted? Does the patient know? Yes ☐ No ☐

○ ○ Are there any learning disabilities? If yes, explain_____

Patient height_____ Expected height of patient_____

Father's height_____ Mother's height_____

○ ○ Are there other children in the family? Yes ☐ No ☐

Names and ages_____

○ ○ Has any other member of the family had orthodontic treatment?

○ ○ Has any other member of the family been a patient of this office? Name_____

○ ○ Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment_____

_____

Please describe why you sought this consultation:_____

_____

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 (underbite)

☐ 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

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: _____