DENTAL HISTORY:

Have any teeth been injured due to accidents or blows to the mouth? ..... YES NO

Have you ever sucked a thumb or finger? ..... YES NO

Until what age? _____

Do you breathe through your mouth

while awake? ..... YES NO while asleep? ..... YES NO

Do you clench or grind your teeth? ..... YES NO

Is there any lip or nail biting? ..... YES NO

Do you have headaches frequently? ..... YES NO

Have you ever had any pain, popping and/or clicking in your jaw joints? ..... YES NO

Right _____ Left _____

Has your jaw ever locked, opened or closed? ..... YES NO

Have you been informed of any missing or extra permanent teeth? ..... YES NO

Has an orthodontist been consulted previously? ..... YES NO

Have you had Orthodontic treatment? ..... YES NO

Who was your Orthodontist? _____ When? _____

Has anyone in your family received Orthodontic treatment? ..... YES NO

Has there been any apprehension or unfavorable experience in a dental office? ..... YES NO

Do you vomit, gag or faint easily? ..... YES NO

When was your last visit to the dentist? _____

Have you gone through a Preventive Program with your dentist? ..... YES NO

Are you self-conscious about your dental problem? ..... YES NO

What do you think is wrong with your teeth?

_____

_____

_____

What concerns do you have about braces, orthodontic treatment, etc.?

_____

_____

_____

The above information is complete and correct to the best of my knowledge.

Patient's Signature _____ Date _____

WELCOME TO WAKHAM ORTHODONTICS

Welcome to our office:

The following information is requested to enable me to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records and your health, is confidential.

Thank You.

Patient's Name _____ (FIRST / MIDDLE / LAST) Age_____ Date of Birth_____ Sex_____

Home Address _____ (STREET / CITY / ZIP CODE)

Home Phone_____ Cell Phone_____

Email _____

Physician_____ Dentist_____ Referred By _____

Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Occupation_____ Employer_____

Business Address _____ Telephone _____ Soc. Sec. #_____

Name of Spouse_____ Employer_____

Business Address_____ Telephone _____ Soc. Sec. # _____

Person(s) Responsible For Account _____

Home Address (if other than above) _____

Employer_____ Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Orthodontic Insurance_____ Date of Birth_____

MEDICAL HISTORY: Circle those that apply

Asthma	Diabetes	Heart Disease	Rheumatic Fever
Anemia	Epilepsy	Hearing Disorder	Speech Disorder
Blood Disease	Endocrine Problems	Head or Face Injury	Risk Group for Aids
Bone Disorder	Emotional Problems	Hepatitis	Other (describe below)

COMMENTS: _____

_____

Has the patient been under a physician's care during the past 2 years, other than routine examination? YES NO

WHY? _____

Do you take any medication? ..... YES NO

If so, please state _____

Are tonsils still present? ..... YES NO

Are there any allergies? ..... YES NO

Sulfa, Penicillin, others? _____

Have you had severe nasal difficulty? ..... YES NO

Have you had psychologic counseling? ..... YES NO

If yes, briefly describe

Would you consider your health to be: Excellent_____ Good_____ Fair_____ Poor_____

(Complete Reverse Side)