

**DENTAL HISTORY:**

Does the patient have pain or clicking in jaw joint? ..... YES NO  
Have any teeth been injured due to accidents or blows to the mouth? ..... YES NO  
Has the patient received or been requested to receive speech correction? ..... YES NO

The following habits are of interest. List information as it pertains to this patient?

Thumb sucking until age \_\_\_\_\_ Grinding of teeth ..... YES NO  
Finger sucking until age \_\_\_\_\_ Tongue thrusting ..... YES NO  
Lip-biting or sucking ..... YES NO Other habits ..... YES NO

Has the patient had any unusual dental experiences? ..... YES NO

If so, what happened? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last dental check up \_\_\_\_\_ Were the patient's teeth cleaned? YES NO

Have any teeth been extracted with the intent of making more space for other teeth to erupt? ..... YES NO

If so, by whom and approximately when? Doctor \_\_\_\_\_ Year \_\_\_\_\_

Has the patient ever worn space maintainers? ..... YES NO

Has the patient ever worn braces? ..... YES NO

If so, under whose care? Doctor \_\_\_\_\_ When \_\_\_\_\_

Has the patient ever seen another orthodontist? ..... YES NO

Do both parents have straight teeth? ..... YES NO

Has either parent had his/her teeth straightened? Father \_\_\_\_\_ Mother \_\_\_\_\_

Has patient's brother or sister had his/her teeth straightened? ..... YES NO

Whom do you think the patient's face most resembles?

Mother? \_\_\_\_\_ Father? \_\_\_\_\_ Combination? \_\_\_\_\_

Height of patient's mother: \_\_\_\_\_ feet \_\_\_\_\_ inches Height of patient's father: \_\_\_\_\_ feet \_\_\_\_\_ inches

Is the patient an adopted child? ..... YES NO

Names and ages of other children in family? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What type of student is the patient? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

What are the patient's hobbies or interests? \_\_\_\_\_  
\_\_\_\_\_

Does the patient play a musical instrument with his/her mouth? ..... YES NO

If so, which instrument? \_\_\_\_\_ How long has he/she played? \_\_\_\_\_

What do you think is wrong with your child's teeth? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child concerned about the appearance of his/her teeth? ..... YES NO

Does your child want straight teeth? ..... YES NO

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

Signed \_\_\_\_\_ Date \_\_\_\_\_

# WELCOME TO WAKHAM ORTHODONTICS

The following information is requested to enable me to give your child the best consideration of their orthodontic problem during their 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 \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
LAST FIRST MIDDLE NICKNAME

Home Address \_\_\_\_\_  
STREET CITY ZIP CODE

Home Phone \_\_\_\_\_ Mother's Cell \_\_\_\_\_ Father's cell \_\_\_\_\_

Email: \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Other Telephone Number for Emergency \_\_\_\_\_

Patient's Physician \_\_\_\_\_ Patient's Dentist \_\_\_\_\_ Referred By \_\_\_\_\_

Father's Full Name \_\_\_\_\_ Mother's Full Name \_\_\_\_\_

Father's Birthday \_\_\_\_\_ Mother's Birthday \_\_\_\_\_

Father's Soc. Sec. # \_\_\_\_\_ Mother's Soc. Sec. # \_\_\_\_\_

Father Employed By \_\_\_\_\_ Mother Employed By \_\_\_\_\_

Position/Occupation \_\_\_\_\_ Position/Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Address \_\_\_\_\_

Work Telephone Number \_\_\_\_\_ Work Telephone Number \_\_\_\_\_

Is Patient Living with Both Parents? \_\_\_\_\_ If No, With Whom? \_\_\_\_\_

Person(s) Responsible For Account \_\_\_\_\_ Orthodontic Insurance \_\_\_\_\_

Address (if other than above) \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Social Sec. # \_\_\_\_\_ 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 the care of a physician during the past two years, other than for routine examination? ..... YES NO  
 WHY? \_\_\_\_\_

Present drugs or medication: \_\_\_\_\_

Birth Defects: \_\_\_\_\_

Has the patient reached puberty? ..... YES NO

Does the patient have any severe emotional or mental disturbance? ..... YES NO

If yes, briefly describe: \_\_\_\_\_

**RESPIRATORY HISTORY:**

Does the Patient:

1. Have allergies to: Seasonal grasses \_\_\_\_\_ Food \_\_\_\_\_  
Drugs \_\_\_\_\_ Other \_\_\_\_\_

2. Snore when sleeping? ..... YES NO

3. Breathe through mouth? ..... Seldom Sometimes Usually

4. Have frequent colds? ..... YES NO

5. Have frequent "stuffy nose or sore throat"? ..... YES NO

6. Have chewing or swallowing difficulty? ..... YES NO

Has the patient received medical treatment from allergist or ear, nose and throat specialist? ..... YES NO

If Yes, When \_\_\_\_\_ By Whom \_\_\_\_\_

For What \_\_\_\_\_

(Complete Reverse Side)