

DENTAL HISTORY

Name of Dentist: _____ Date of last visit: _____

1. Have there been any injuries to the face, mouth, teeth? YES NO
2. Has the patient had or presently have any of the following habits: Thumb/finger sucking Grinding of teeth
Lip biting Snoring Mouth breathing None
3. Has the patient been informed of any missing or extra permanent teeth? YES NO
4. Is the patient aware of sores, lumps or irritated areas in the mouth? YES NO
5. Has an orthodontist been consulted previously? YES NO

Name: _____ Date: _____

6. Has the patient ever been treated for Bad Bite TMJ Periodontal Disease NO

If so, by whom: _____

7. Does the patient have any speech problems? YES NO
8. Is the patient frightened or anxious about Orthodontics or Dentistry? YES NO
9. Is the patient concerned about the appearance of their teeth? YES NO
10. Is there anything the patient would like to change about his/her smile? YES NO

If so, what: _____

11. What aspect of dental treatment is the patient most concerned with?
Quality Cost Discomfort Time

12. Reason for consultation (Chief Concern)? _____

13. Has there ever been any orthodontic treatment for any other member of the family? YES NO
Are you satisfied with the results? YES NO

Mother (Dr. _____) Father (Dr. _____)

Brother (Dr. _____) Sister (Dr. _____)

DENTAL INSURANCE INFORMATION

Name of Company: _____ Phone: _____

Employer: _____

Employee Name: _____ Date of Birth: _____

Social Security Number: _____ Group Number: _____

Name of Company: _____ Phone: _____

Employer: _____

Employee Name: _____ Date of Birth: _____

Social Security Number: _____ Group Number: _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of dental benefits otherwise payable to me directly to the orthodontist.

Signature: _____ Date: _____