Dental and Medical Information

First Name _____ Last Name _____

What is your main reason for seeing an orthodontist? (check all that apply)

- ☐ Bad Bite
- ☐ Crowding
- ☐ Missing / Extra Teeth
- ☐ Overbite / Underbite
- ☐ Crooked Teeth
- ☐ Gummy Smile
- ☐ Spacing
- ☐ Thumb / Finger Habit
- ☐ Crossbite
- ☐ Jaw Pain
- ☐ Other: _____

Are you anxious about treatment? ☐ Yes ☐ No **Did you have a bad dental experience?** ☐ Yes ☐ No

What type of braces are you most interested in? ☐ Metal ☐ Clear ☐ Invisible ☐ Invisalign

What aspect of treatment are you most concerned with? ☐ Aesthetics ☐ Comfort ☐ Cost ☐ Quality ☐ Time

Any history of:

- ☐ Clicking in Jaw Joints
- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Finger / Thumb Sucking
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Lip Biting
- ☐ Mouth Breathing
- ☐ Nail Biting
- ☐ Pain in Jaw Joints
- ☐ Snoring
- ☐ Speech Problems
- ☐ Tongue Thrusting
- ☐ None of the Above

Is this a second opinion? ☐ Yes ☐ No If yes, who did you previously see? _____

Any previous Orthodontic Treatment? ☐ Yes ☐ No If yes, who did you previously see? _____

Have you been treated for TMJ / TMD? ☐ Yes ☐ No If yes, who did you previously see? _____

Have you been treated for gum disease? ☐ Yes ☐ No If yes, who did you previously see? _____

Who is your General Dentist? _____

When did you have your last visit? _____ Did your dentist recommend an orthodontist? ☐ Yes ☐ No

Brush teeth daily? ☐ Yes ☐ No **Frequency of flossing:** ☐ Daily ☐ Weekly ☐ Sometimes ☐ Never

Is medication needed before dental treatment or cleanings? ☐ Yes ☐ No ☐ Uncertain

If so, why? _____

Have you reached puberty? ☐ Yes ☐ No

If female, has menstrual cycle started? ☐ Yes ☐ No

Over a year ago? ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No

Is there a chance you may be pregnant? ☐ Yes ☐ No

Do you have a tendency for the following: ☐ Ear Infections ☐ Colds ☐ Sore Throats

Please complete the back of this form

Do you currently have or have you ever had any of the following medical conditions?

- ☐ ADD/ADHD
- ☐ Allergies/Asthma
- ☐ Arthritis
- ☐ Aspergers/Autism
- ☐ Autoimmune Disorder
- ☐ Blood Disease
- ☐ High / Low Blood Pressure-which?
- ☐ Bone Disorders / Osteoporosis
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Hearing Disorders
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Sleep Apnea / Disturbance
- ☐ Tourette Syndrome
- ☐ Trauma to Face, Head, Jaws, Teeth
- ☐ None of the Above

Are there any other medical conditions we should be aware of? _____

Are you taking any of the following medications?

- ☐ Bisphosphonates (bone density drugs)
- ☐ Blood Thinners
- ☐ Heart Medication
- ☐ Insulin
- ☐ Pain Medication (What medication and why?) _____

Please list any medications you are taking: _____

Have the tonsils or adenoids been removed? ☐ Yes ☐ No

Are there any sores, lumps, or irritated areas in the mouth? ☐ Yes ☐ No

Do you have a latex allergy? ☐ Yes ☐ No **Are you allergic to Nickel?** ☐ Yes ☐ No

Please list any other allergies: _____

I acknowledge that I have read over and answered all questions on this form and that the information I have given is correct to the best of my knowledge. This information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.

Signature _____ **Date** _____

Privacy Policy Notice

I _____ acknowledge that I have reviewed the Privacy Policy Notice for The Big Smile Orthodontics

Signature _____ **Date** _____

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for refusal to sign: _____

Privacy Director's Signature _____ **Date** _____