PATIENT INFORMATION

Date *m*_____ *d*_____ *y*_____

Name____ Sex m f

Birth date *m*_____ *d*_____ *y*_____ Age_______ Occupation____________________

Address________________________ City______________ Postal__________

Home phone ( )________________ Business phone ( )________________

Email____

Person responsible for the account____________________ Insurance coverage yes no

Dentist________________________ Referral source____________________

Activities which may affect orthodontic treatment____________________________

1. Have you had a dental check-up in the last three months? . . . yes no
2. Does your bite feel comfortable? . . . . . . yes no
3. Are you satisfied with the appearance of your teeth? . . . . yes no
4. Have you had previous Orthodontic treatment? . . . . . yes no
5. Has another Orthodontist been consulted? . . . . . yes no
6. Is there any history of injury to your teeth or jaw? . . . . yes no
7. Do you have a general habit of breathing through your mouth? . . . yes no
8. Is there any difficulty chewing food? . . . . . . yes no
9. Are there any sore or loose teeth? . . . . . . yes no
10. Is there a history of periodontal (gum) problems, including bleeding? . . yes no
11. Have you been told by a dentist that you have a problem with your gums? . yes no
12. Have you had any special treatment of your gums by a dentist or periodontist? . yes no
13. Have you had a root canal treatment? . . . . . . yes no
14. Do any of your teeth have crowns, caps or bridges? . . . . yes no
15. Do you have frequent headaches (twice weekly or more)? . . . yes no
16. Is there any clicking, cracking or popping noises in your jaw? . . . yes no
17. Do you experience any stiffness, tiredness or locking of the jaw? . . . yes no
18. Do you experience any pain in your jaw, face or head? . . . . yes no
19. Do you experience any pain in your neck or back? . . . . yes no
20. Do you grind or clench your teeth? . . . . . . yes no
21. Have you had any treatment for jaw problems? . . . . . yes no
22. Have you had any wisdom teeth removed? . . . . . yes no
23. Please describe your concerns about your teeth in your own words: