**MEDICAL HISTORY**

Is the patient in good health? _____ Does the patient have any history of major illness? ___________________

Please list (give dates) ____________________________________________________________________________

**CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED**

- HEART TROUBLE
- HIV/AIDS
- ATTENTION DEFICIT
- LIVER INVOLVEMENT
- MITRAL VALVE PRO
- ANEMIA
- KIDNEY PROBLEMS
- HEPATITIS
- HEART MURMUR
- EPILEPSY
- ENDOCRINE PROBLEMS
- BLOOD DISORDERS
- RHEUMATIC FEVER
- ASTHMA
- PROLONGED BLEEDING
- DIABETES
- NEUMONIA
- FAINTING OR DIZZINESS
- TUBERCULOSIS
- OTHER _______

Does patient have tendency to: Colds _____  Sore Throats _____  Ear Infections _____  Cold Sores  _________________

Have tonsils and adenoids been removed? _____  What Age? ______  List any drugs or medications now being taken and reason. __________________________________________________________________________________________

**LIST ANY ALLERGIES OR DRUG SENSITIVITY**

Has the patient reached puberty:   Girls-has she started menstruation _____  If so date of onset  _____________________

Boys-has his voice changed  __________________________________________________________________________

**DENTAL HISTORY**

Date of last dental cleaning __________________ Date of last X-rays __________________

Has the patient had a Panoramic/Panorex X-ray?  Y / N / Don’t know  If yes, When? ______

Have there been injuries to the face, mouth or teeth?  Y / N  If yes, describe and give date __________________________

Has the patient ever sucked a thumb or fingers?  Y /N  Age  ______________

Any pain in or near the ears?  Y / N  Does the patient have any speech problems?  Y / N

Have you been informed of any missing or extra permanent teeth?  Y / N

Has an orthodontist been consulted previously?  Y / N  Has either parent had orthodontic treatment?  Y / N

List any musical instruments played __________________

Interests or hobbies __________________

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This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature (parent or guardian’s) __________________
OFFICE USE
Date ________________________________

Chief complaint ______________________________________________________________________________________________
Habits: ____________________________________________________________________________________________________
Trauma ____________________________________________________________________________________________________

TMJ EXAMINATION: Does patient have or report any TMD Symptoms:  Y / N  TMD History Required:  Y / N
Comments: _________________________________________________________________________________________________

Extra oral exam
Frontal: Square-Ovoid-Round-Tapering  Symmetry:  Gingiva @ smile:
Incisor at rest:  Incisor @ smile: 
Negative Space: none-mild-mod-severe  SmileToothContour: reverse-flat-avg

Intra oral exam
Frenum: high-avg-low  Diastema:  Pathology: 
Hygiene: 1 2 3 4 5 (5 best)  Attached Gingiva:  
Notes: 

Midlines | Nose
---|---
Mx Dental
Mn Dental
Chin

Crowding/Spacing Maxilla mm Mandible mm CR/CO mm direction __
Angle class: RM RC LM LC OJ= mm OB= mm Crossbites __
Comments: _________________________________________________________________________________________________

___________________’s RECOMMENDATION

RADIOGRAPHS NEEDED: Pano _____ Lateral Ceph_____ PA Ceph_____ Periapical _____ Other _____
Interceptive Tx ________________________________ Limited Tx ________________________________
Full Tx ________________________________ Habit Tx ________________________________
Consults Needed ________________________________ Extractions ________________________________
Tx time ________________________________ Orthognathic Surgery ________________________________
Fee Range ________________________________ Stage: One Two Three ________________________________
Disposition: Recall (months) Records ________________________________ Will call ______ No tx ________________________________

N1V: ______
N2V: ______
N1V: ______
N2V: ______

Insurance confirmed with patient ~ Letter to GD ~ Procedure Letter ~ Pre-authorization sent