

DENTAL HISTORY

Has the patient ever sucked a thumb or fingers? _____ Yes No Until what age? _____

Does the patient have any speech problems? _____ Yes No

Is the patient a mouth breather? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

If (yes), the who _____ Where ? _____ When ? _____

Please circle your reasons for seeking orthodontic advice.

Crowding	Receded jaw	Clicking jaw joint	Space between teeth	Headaches/Facial pain
Over-bite	Prominent jaw	Irregularly shaped teeth	Missing teeth	Jaw Pain
"Buck" teeth	Gummy Smile	Protrusion of teeth	Ringling/Stuffiness of ears	Other: _____

Is patient pregnant? Yes _____ No _____ If yes, when is baby due? _____

Does the patient have or ever been treated for problems with jaw joints or facial muscle spasms? _____ Yes No
(Mouthguard, splint, or other devices worn between the teeth?)

If (yes), please explain _____

Does patient experience any problems on opening or closing jaw when speaking, eating, other? _____ Yes No

If (yes), please explain: _____

Does patient grind or clench his/her teeth? _____ Yes No

Has patient ever had periodontal (gum) treatment? _____ Yes No

If (yes), please explain _____

Has patient ever had any teeth removed? _____ Yes No

If (yes), please explain _____

Does patient have any difficulty chewing or swallowing food? _____ Yes No

Are patient's teeth or gums sensitive to heat, cold, or pressure? _____ Yes No

Does patient play any musical instrument that touches his/her lips? _____ Yes No

Has patient ever had trauma or an accident to the head, face, jaws, or teeth? _____ Yes No

If (yes), please explain _____

To the best of my knowledge, all of the preceding answers are true and correct. If there are ever any changes in health status and/or medications, I will inform Dr. Colb/Dr. Hunter at the next appointment. I also grant the right to Dr. Colb/Dr. Hunter to release health information regarding my (or my child's) orthodontic treatment to third party payors and/or other health practitioners.

Signature of Patient, Parent or Legal Guardian: _____

Please print name: _____

Reviewed by Dr. Michael A. Colb: _____
Date: _____

Updated _____

Updated _____

Reviewed by Dr. Craig Hunter: _____
Date: _____

Updated _____

Updated _____