Patient's Name _____ Patient's Birthdate _____

CURRENT AND PAST MEDICAL HISTORY (please circle)

Currently under physician's care? ..... Yes No
Taking medications? ..... Yes No
Previous hospitalizations? ..... Yes No
Activities limited? ..... Yes No
Emotional or behavioral problems? ..... Yes No
Tonsils removed? Month ..... Year..... No
Adenoids removed? Month ..... Year..... No

HAS THE PATIENT ANY HISTORY OF THE FOLLOWING (please circle)

Rheumatic fever ..... Yes No
Heart problems ..... Yes No
Blood pressure problems ..... Yes No
Bleeding problems ..... Yes No
Premedicate for dental procedures ..... Yes No
Anemia ..... Yes No
Hepatitis or liver problems ..... Yes No
Asthma or respiratory disease ..... Yes No
Epilepsy or convulsions or seizures ..... Yes No
Unusual childhood diseases ..... Yes No
Thyroid problems ..... Yes No
Diabetes ..... Yes No
Dizziness or fainting ..... Yes No
Birth defects ..... Yes No
Poor vision ..... Yes No
Poor speech ..... Yes No
Poor hearing ..... Yes No
Sore throat ..... Yes No
Allergies ..... Yes No
Osteoporosis ..... Yes No
*Please explain briefly any yes answers circled above.

List any medications, including OTC's and supplements

Have there been any illnesses or injuries; any physical limitations?

Dentist's Name _____

Date of most recent dental cleaning _____

Approximate date of first dental visit _____

CURRENT AND PAST DENTAL HISTORY (please circle)

Has the patient previously worn braces or retainers? ..... Yes No
Has the patient seen another Orthodontist? ..... Yes No
Has anyone in the family worn braces? ..... Yes No
Does the patient's mouth resemble others in the family? ..... Yes No
Have any teeth been extracted? ..... Yes No
Are there any problems with the jaw joint? ..... Yes No
Have there been any injuries to the teeth or jaws? ..... Yes No
Have any teeth been bonded? ..... Yes No

Cooperation at the dentist is:
☐ Excellent ☐ Good ☐ Fair ☐ Nervous ☐ A problem

How do you think the patient will react to orthodontic treatment?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Why?

Do any of the following habits exist?

☐ Grinding teeth	☐ Fingernail biting
☐ Lip sucking	☐ Lip biting
☐ "Abnormal" swallowing	☐ Tongue thrusting
☐ Thumb or finger habit	☐ Mouth breathing

ORAL HYGIENE

Does the patient have any gum disease? ..... Yes No
Do the patient's gums bleed during brushing? ..... Yes No
The patient brushes: ☐ Once ☐ Twice ☐ 3x/day ☐ Other
The patient uses dental floss: ☐ Daily ☐ Occasionally ☐ Never

IF THE PATIENT IS UNDER 16 YEARS OLD, PLEASE ANSWER THE FOLLOWING:

Baby teeth came in ☐ Average ☐ Early ☐ Late
Permanent teeth came in ☐ Average ☐ Early ☐ Late
Emotional maturity is ☐ Normal ☐ Adultlike ☐ Childlike
Height (compared to peers) ☐ Average ☐ Tall ☐ Short Ht. . . . . .
Growth and development ☐ Slow ☐ Normal ☐ Advanced Wt. . . . . .
Menstrual Period Started ☐ No ☐ Yes . . . . . Month . . . . . Year

Signature _____ Date _____ Doctor's Signature _____ Date _____
Parent or guardian if patient is under 18 years old

PLEASE COMPLETE BOTH SIDES OF THIS FORM

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Please complete the following questions to help us understand how you came to our office, what your concerns are and provide us with important health history information

What is your dental concern?

Has your dentist mentioned any concerns?

Questions you would like answered at your appointment

Reasons you chose Barrer & White Orthodontists. Please check all that apply:

Dentist or hygienist asked you to check with us specifically ..... ☐

Dentist or hygienist advised you to consult with an orthodontist ..... ☐

Dentist or hygienist gave you several choices of orthodontic offices ..... ☐

Dentist advised you to go elsewhere but you chose our office ..... ☐

Names of friend or family member who gave you a strong recommendation .....

.....

Names of family members who have been seen or are being treated by us .....

.....

Internet search ..... ☐

Website ..... ☐

Location ..... ☐

Insurance company ..... ☐

Advertisement…….. ☐ Where? .....

Other ……☐ Please explain .....

Is there a chance that you may be moving away from this area while in treatment?
☐ No ☐ Yes If yes, please explain: