Date ___________________________________

Patient's Name____ **Nickname** ______________________________

Date of Birth ___________________________________**Age** _________**Height**_____________ **Weight** ____________

Male or Female Grade______________**School**____

Dental History

Please describe your main concern and reason for this examination today. ____

____

General Dentist's Name: ____

How often are your dental check ups? ___________________________When was your last visit? _________________________

Patient's preferred Oral Surgeon, if any? ____

Name of person who referred you here, if other than your General Dentist? ____

Is patient an adopted child? Yes No

Has patient ever had an injury to the face, mouth, or teeth? Yes No

If yes, Please describe. ____

Has patient ever sucked a thumb or finger? Yes No Until what age? ______________

Does patient breath primarily through the mouth rather than the nose? Yes No

If so, while awake or asleep? ____

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

Has an orthodontist been previously consulted? Yes No

Has a sibling or parent ever have orthodontic treatment? Yes No

Does the patient have a history of lip biting or sucking? Yes No

Does the patient have a history of grinding his/ her teeth? Yes No

Does the patient play any musical instruments? Yes No

If yes, what? ____

Favorite sports, hobbies, or activities? ____

Does the patient smoke or use tobacco products? Yes No

Does the patient brush regularly? Yes No Floss? Yes No

Use a fluoride rinse? Yes No

How would you rate the patient's oral health? ____

Questions, comments or concerns? ____