

DENTAL HISTORY

HAVE YOU HAD PREVIOUS ORTHODONTIC CARE OR CONSULTATION? YES NO

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

YES	NO	ANY INJURIES TO THE:	<input type="checkbox"/> FACE	<input type="checkbox"/> MOUTH	<input type="checkbox"/> TEETH
		TOOTHACHE			
		TEETH SENSITIVE TO	<input type="checkbox"/> HOT	<input type="checkbox"/> COLD	
		GUM DISEASE			
		LUMPS OR SORES IN MOUTH			
		HERPES/APTHOUS ULCERS			
		SPEECH PROBLEMS?			
		HAVE YOU EVER SUCKLED A THUMB OR FINGER? UNTIL WHAT AGE?	_____		
		ARE YOU A MOUTH BREATHER?	<input type="checkbox"/> WHILE AWAKE	<input type="checkbox"/> WHILE A SLEEP	
		ARE YOU AWARE OF ANY :	<input type="checkbox"/> MISSING TEETH	<input type="checkbox"/> EXTRA PERMANENT TEETH	

HAVE YOU EVER HAD ANY PROBLEMS OR SIDE EFFECTS ASSOCIATED WITH PREVIOUS DENTAL CARE? YES NO

WHEN DID YOU LAST HAVE DENTAL EXAM AND CLEANING? _____

ARE THERE ANY FILLINGS/CROWNS STILL TO BE DONE? YES NO IS THE APPOINTMENT SCHEDULED? YES NO
IF YES, DATE: _____

TMJ

YES	NO	DO YOU CLENCH OR GRIND YOUR TEETH?			
		DO YOU EVER HEAR:	<input type="checkbox"/> CLICKING	<input type="checkbox"/> GRINDING SOUNDS IN YOUR JAW JOINT?	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT
		HAVE YOUR JAWS EVER LOCKED:	<input type="checkbox"/> OPEN?	<input type="checkbox"/> CLOSED?	
		DO YOU GET FREQUENT:	<input type="checkbox"/> HEADACHES?	<input type="checkbox"/> SORE FACIAL MUSCLES?	
		DO YOU WANT ORTHODONTIC TREATMENT IF INDICATED?			

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____

OFFICE USE ONLY

TC NOTES _____

CLINICAL OBSERVATIONS _____

ESTIMATED: COST _____
TIME _____

PROVISIONAL TREATMENT PLAN _____

