

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: FACE MOUTH TEETH

TOOTHACHE

TEETH SENSITIVE TO HOT COLD

GUM DISEASE

LUMPS OR SORES IN MOUTH

HERPES/APTHOUS ULCERS

SPEECH PROBLEMS?

HAVE YOU EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? _____

ARE YOU A MOUTH BREATHER? WHILE AWAKE WHILE A SLEEP

ARE YOU AWARE OF ANY : MISSING TEETH 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: CLICKING GRINDING SOUNDS IN YOUR JAW JOINT? LEFT RIGHT

HAVE YOUR JAWS EVER LOCKED: OPEN? CLOSED?

DO YOU GET FREQUENT: HEADACHES? 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 _____