



HAVE YOU HAD TONSILS OR ADENOIDS REMOVED? AT WHAT AGE? \_\_\_\_\_

THE FOLLOWING QUESTIONS HAVE TO DO WITH GROWTH:

GIRLS - HAVE YOU STARTED MENSTRUATION? AT WHAT AGE? \_\_\_\_\_ ARE YOU TAKING CONTRACEPTIVES?  YES  NO

BOYS-HAS YOUR VOICE CHANGED?

PARENTS' HEIGHT: MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

LIST SPORTS, HOBBIES AND INTERESTS \_\_\_\_\_

### 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 \_\_\_\_\_