Date: _________

WELCOME

Name______________________________________Nickname_____________________ Sex______

Age_________ Date of Birth_______________ EMAIL ____

Mailing Address_________________________________ Telephone_____________________________

City _______________________________ State_______ Zip code ___________________________

Referred to this office by ____

General Dentist___________________________ Physician____________________________

Employer _______________________________ Occupation ______________________________

Bus. Telephone____________________________ social security number_______________________

Spouse _________________________ employer ____

Telephone ____________________ social security number ______________________________

Name & telephone of someone to contact if spouse not available: ____

Are you in good health? ________Any history of major illness (please explain) ______________________________
____

Allergies ____

Check the following previous or current medical conditions:

_____ AIDS/HIV
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Bleeding disorders
_____ Bone disorders
_____ **COVID-19**

____Diabetes
____ Epilepsy
____ Endocrine disorders
____ Fainting or dizziness
____ Heart disorders
____ Kidney disorders
Other-specify_________________

_____ Hepatitis
_____ Lung disorders
_____ Nervous disorders
_____ Pneumonia
_____ Tuberculosis
_____ Cerebral Palsy

Are you or is there a possibility you are pregnant? _____________

Do you wear contact lenses? _______ Tendency to colds, sore throats, ear infections______

List current medications (prescription or over counter) ____
____

When was your last dental examination? _____________________________

Any injuries to the face, mouth or teeth? _______ Habits? ______________

Are you a mouth breather? _________ asleep _________ awake _________

Do you grind your teeth? ________ asleep _______ awake ________

Do you have any speech problems? _______ present therapy _______

Do you play a musical instrument? _______ what kind ____________

How often do you brush your teeth:
___several times a day ____ once a day ___ occasionally

Past or present history of periodontal disease and or treatment? (please explain) ______________________________
____

Past or present history of TMJ problems? (please explain) ____
____

Have you been informed of any missing or extra permanent teeth ? _____________________

Have you or any other family member had orthodontic treatment ? ______________________

Your reason for seeking treatment ____
____

Were you aware of this problem? ________

What best describes your attitude toward orthodontic treatment:

___wants treatment ____unwilling, but agrees

___ willing if necessary ____ uncooperative

Thank you for choosing our office for possible treatment.
Please do not hesitate to ask any questions during the exam.