

DENTAL HISTORY

Dentist's Name: _____ City: _____ Phone: (____) _____ - _____

Dental Specialist Name: _____ City: _____ Phone: (____) _____ - _____

What are the main concerns that you would like orthodontics to accomplish? _____

Who first noticed the orthodontic problem? Patient Dentist Other _____

What are the chief concerns you have related to the position of your teeth or bite:

- | | |
|--|--|
| <input type="checkbox"/> Appearance / Smile | <input type="checkbox"/> Difficulty Cleaning / Gum Problem |
| <input type="checkbox"/> Comfort / Bite | <input type="checkbox"/> Ability to Chew / Function |
| <input type="checkbox"/> Stability / Shifting | <input type="checkbox"/> Wear / Fractures of Teeth |
| <input type="checkbox"/> Jaw Joint / Muscle Discomfort | <input type="checkbox"/> Alignment of teeth prior to restoration of dental work (crowns, implants, etc.) |

Have you had any injury to the face, mouth, chin or teeth? No Yes Explain: _____

Are you apprehensive about dental treatment? No Yes Prior unpleasant experience? _____

Have you consulted an orthodontist previously? No Yes With whom? _____

Have you had any previous orthodontic treatment? No Yes Satisfied? _____

Have permanent teeth been removed? No Yes Explain: _____

Have you noticed any recent changes in your bite or dental alignment? No Yes Explain: _____

Do you have any speech problems or tongue thrust? No Yes Explain: _____

Do you clench or grind your teeth during the day or night? No Yes Aware of tooth wear? _____

Have you experienced jaw joint (TMJ) soreness, popping, or difficulty opening? No Yes Explain: _____

Do you generally breathe through your mouth? No Yes While awake? _____

Is there any other information that may be helpful? _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY

Are you currently under physician's care? No Yes Explain: _____

Are you currently taking medications? No Yes List: _____

Do you take medication (bisphosphorates) for osteoporosis? No Yes List: _____

Do you have allergies or drug sensitivities? Latex? No Yes List: _____

Do you need pre-medication before dental work? No Yes Explain: _____

CHECK ONLY IF YOU HAVE BEEN TREATED FOR:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Anemia or prolonged bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease or murmur | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma or hay fever | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Hepatitis or liver disease | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Bone disorder/Osteoporosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes (fever blisters) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> HIV positive (AIDS) | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chronic sinus problems | <input type="checkbox"/> Frequent or severe headaches | | |

Any other conditions you think we should know about? _____

Signature _____ Date ____/____/____

Thank you for taking the time to fill out this form.

Samuel L. Lake, DDS, MSD, PS

*Specialist in Orthodontics
for Children and Adults*

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