100 S. Imperial Hwy, #B
Anaheim Hills, CA 92807
714-637-6700

Date_______________

Patient's Name _____________________________________ Age ____

Gender _____ SS#_____-___-______ Date of Birth _____ / _____ / _____

Street Address ____

City _____________________ State _______ Zip Code ______________

Home Phone ( ) __________________ Cell Phone ( ) ________________

E-mail address ____

Employed By ____

Work Contact Number ( ) ____________________________

Marital Status is Single Married Divorced Widowed Other

Spouse's Name (if applicable) ___________________________

Children

Name ________________ Age _____ Name _________________ Age ______

Name ________________ Age _____ Name _________________ Age ______

Whom may we thank for referring you to our office? _____________________________

Have you ever had any orthodontic treatment? _______ If yes, at what age? _________

Has anyone in your family had orthodontic treatment in our office? ________________

If yes, their first and last name, and relationship to patient _________________________

Dental History

Dentist's Name______________________ Phone number ___________________

Address____

City_____________________ State _____________ Zip Code _______________

When was your most recent dental visit? ___________________

What is your primary concern that prompted you to schedule an appointment for an orthodontic consultation?

____

____

Have you noticed or has your dentist mentioned any of the following?

Spacing between the teeth	Yes No
Teeth are rotated or crowded	Yes No
The front teeth are protruding	Yes No
An excess overbite (overlap of the front teeth)	Yes No
There is an underbite (lower teeth too far forward)	Yes No
The lower jaw is too far back or too far forward	Yes No
An open bite (front teeth do not come together)	Yes No
Permanent teeth missing	Yes No
Have you ever had an injury to the face, neck, jaws, or teeth?	Yes No
Do you have difficulty in opening your mouth wide?	Yes No
Do your jaws ever click or pop?	Yes No
Do you have pain in front of the ears?	Yes No
Do you have temporomandibular joint (TMJ) problems?	Yes No
Do you have frequent headaches, neck pain, or back pain?	Yes No

Please circle any current or former habits related to the teeth

teeth-grinding tongue thrust thumb-sucking nail-biting mouth-breathing

Do you have a specific interest in *Metal braces* *Clear braces* *Invisalign* *Retainers*

Pertinent Medical History

Physician's Name ___________________________ Phone (   ) ___________________

Are you currently taking any prescription medications?   Yes   No

Please list all current medications (prescription and over-the-counter)

_______________________ _________________________ ____________________

_______________________ _________________________ ____________________

Are you allergic to any of the following?

Latex	Yes No	
Penicillin	Yes No	
Other Antibiotics	Yes No	if Yes ______________
Metals or Plastics	Yes No	
Do you use tobacco?	Yes No	In the past but not now

Have you ever had any of the following medical conditions?

Abnormal or prolonged bleeding	Yes No	
Artificial heart valve	Yes No	
Artificial joint	Yes No	
Asthma	Yes No	
Cancer, chemotherapy, radiation treatment	Yes No	
Congenital heart condition	Yes No	
Diabetes	Yes No	
Dry mouth (xerostomia)	Yes No	
Epilepsy or Seizures	Yes No	
Heart murmur	Yes No	
Heart pacemaker	Yes No	
Hepatitis	Yes No	
HIV or AIDS	Yes No	
Hives or skin rash	Yes No	
Osteoporosis	Yes No	
Sinus problems	Yes No	
Any other condition that is pertinent	Yes No	______________________

Women - If you are pregnant or think you may be pregnant, please notify our office.

The above dental and medical history is accurate to the best of my knowledge. I hereby give consent for an orthodontic examination.

Signature of Patient _________________________________***Date***_______________