100 S. Imperial Hwy, #B
Anaheim Hills, CA 92807

714-637-6700

Date _____

Patient's Name _____ Age ____

Gender _____ Date of Birth _____ / _____ / _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____

E-mail address _____

Parents are Married Divorced Widowed Other

Father's Name _____D.O.B. ____/____/____ SS# _____-___-_____

Contact Number ( ) _____ Employed By _____

Mother's Name _____D.O.B. ____/____/____ SS#_____-___-_____

Contact Number ( ) _____ Employed By _____

Siblings

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 the patient's 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
Excess overbite (overlap of the front teeth)	Yes No
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 are 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

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

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
Metals or Plastics	Yes No

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 medical condition that you think is pertinent _____

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

Signature of Parent/Guardian _____ ***Date***_____