Dear New Patient,

My staff and I are looking forward to meeting you on your appointed date and answering any questions you may have about your teeth.

At this first appointment, I will be examining your teeth and will give you an evaluation as to the type of orthodontic treatment that would be best for you and the approximate amount of time involved. I will also present you with the financial options that are available to you.

Please print and fill out the dental health history form and bring it to your appointment. If my staff or I can be of any assistance we invite you to call us.

I welcome you to our practice and look forward to seeing you on your first visit.

Sincerely,

Todd Aki, D.D.S., M.S.

ACQUAINTANCE & HEALTH HISTORY

Date:

PERSONAL INFORMATION

Patient's Name________________________Nickname__________ Sex______
Mailing Address________________________________ Date of Birth ________Age_____
Street city state zip
Home Phone______________ Name of Family Physician______________________
Dentist ______________________Patient's Social Security # ________________
Whom may we thank for this referral. ________________ Hobbies/Interest ____________

RESPONSIBLE PARTY INFORMATION

Relationship to Patient	________	________
Name	________	________
Address & Phone Number	________	________
How Long at This Address	________	________
Employers Name	________	________
Business Phone	________	________
Occupation	________	________
Number of Years Employed	________	________
Social Security Number	________	________
Birth date	________	________
Orthodontic Insurance co	________	________
Coverage (office use only)	________	________

Martial Status ☐ married ☐single ☐divorced ☐widowed

I understand that where appropriate, credit bureau reports may be obtained.
Signature (parent's signature if minor) ____________________

MEDICAL HISTORY

Is the patient in good health? ☐Yes ☐No Reason________________
Any major or unusual illnesses? ☐Yes ☐No Explain________________
Currently under physician's care? ☐Yes ☐No Reason________________
Currently taking medication? ☐Yes ☐No List________________
Allergies ☐Yes ☐No List________________
Drug sensitivity ☐Yes ☐No List________________

Please check if patient has or had any of the following.

☐Anemia
☐Blood Disease
☐Prolonged Bleeding
☐Hepatitis
☐AIDS or HIV positive
☐Jaundice
☐Rheumatic Fever
☐Malignancies, Tumors or Cancer
☐Heart Disease or Murmur
☐Tuberculosis
☐Diabetes
☐Endocrine problems
☐Bone Disorders
☐Epilepsy
☐Herpes or Venereal Disease
☐Emotional Stress
☐ Frequent colds or flu
☐Tonsilitis
☐ Mononucleosis
☐Tonsils removed age________
☐Adenoids removed age_______
☐Asthma
☐Mouth breathing

Growth information for patients under 16 years of age.
Father's Height ____________ Mother's Height ______________ Adopted ☐Yes ☐No
Girls : Has she started menstruation? ☐Yes ☐No When? ________________
Boys: Has his voice changed? ☐Yes ☐No When? ________________
Names and ages of patient's brothers and sisters. ________________
Have any had orthodontic treatment? ☐Yes ☐No When? ________________

DENTAL HISTORY

YES	NO	
☐	☐	Has the patient had any severe head or face injuries? Explain:____________
☐	☐	Has the patient had a history of thumb sucking or finger sucking? Stopped?____________
☐	☐	Does the patient play any musical instruments? What?____________
☐	☐	Has the patient consulted an orthodontist previously? ____________
☐	☐	Has the patient had any previous orthodontic treatment? Explain: ____________

PLEASE CHECK IF THERE IS A HISTORY OF:

- ☐ clenching teeth
- ☐ grinding teeth
- ☐ snoring loudly
- ☐ high decay rate
- ☐ muscular soreness around the head and neck
- ☐ headaches
- ☐ jaw joint soreness
- ☐ mouth breather
- ☐ hard blow to chin
- ☐ jaw joint popping
- ☐ ringing in the ears
- ☐ tongue thrust
- ☐ speech problems or speech therapy

When was the patient's last visit with their dentist? ____________

When was the patient's last dental cleaning? ____________

What do you consider to be your main interest in orthodontics? ____________

Has your dentist pointed to some orthodontic problem? ____________

Does the patient object to braces or any part of orthodontic treatment? ____________

Is there any other information which might be helpful? ____________

THANK YOU Signed:____________ Date:____________

PRELIMINARY EXAM (FOR OFFICE USE ONLY)

TMJ

Max opening ____________ PERIO ____________ CROSSBITE____________

Max left lateral ____________

Max right lateral ____________ CROWDING ____________ SPACING ____________

LIPS ____________ FRENUM ____________ TONGUE ____________

HABITS ____________ CARIES ____________ ROTATIONS ____________

HYGIENE ____________ MIDLINE MAX ____________ TEETH

MAND____________PRESENT

CLASS _____ DIV____ OVERBITE ________ OVERJET ________

FACIAL PROFILE____________

OBSERVATIONS AND RECOMMENDATIONS