

ORTHODONTIC PATIENT INFORMATION

Welcome to our practice! The following information is requested so we can give you the best consideration of your orthodontic problem. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information is confidential. Thank you.

Patient Name _____ Home Phone () _____

Address _____

_____ Business Phone () _____

Date of Birth ___/___/___ Sex: M F Height: _____ Weight _____

Parent/Guardian _____ Phone () _____

Referred by _____

MEDICAL HISTORY: PLEASE CIRCLE THE APPROPRIATE RESPONSE

Allergies _____ Yes/No	Hearing Disorder _____ Yes/No
Asthma _____ Yes/No	Head/Face Injury _____ Yes/No
Anemia _____ Yes/No	Hepatitis _____ Yes/No
Blood Disease _____ Yes/No	HIV +/-HIV _____ Yes/No
Bone Disorder _____ Yes/No	Kidney/Liver Problems _____ Yes/No
Cancer _____ Yes/No	Rheumatic Fever _____ Yes/No
Colds (Frequent) ___ Yes/No	Sore Throat (Frequent) _____ Yes/No
Diabetes _____ Yes/No	Tuberculosis _____ Yes/No
Epilepsy _____ Yes/No	Tonsils Removed _____ Yes/No
Endocrine Problems __ Yes/No	Adenoids Removed _____ Yes/No
Emotional Problems __ Yes/No	Chewing/Swallowing Problems __ Yes/No
Fainting/Dizziness ___ Yes/No	Pain in Jaw Joint _____ Yes/No
Handicaps/Disability __ Yes/No	when Opening _____ Yes/No
Heart Disease/Murmur _ Yes/No	when Closing _____ Yes/No
Menstrual Cycle Started _ Yes/No	

Have any teeth been injured due to accidents or blows to the mouth? _____ Yes/No

Has the patient been requested to receive speech correction? _____ Yes/No

Has the patient had any unusual dental experiences? _____ Yes/No

If yes, please specify _____

Has the patient had previous orthodontic consultation or treatment? _____ Yes/No
If yes, when and by whom _____

Has the patient had any of the following habits:

Thumb sucking until age _____	Grinding of teeth _____	Yes/No
Finger sucking until age _____	Tongue thrusting _____	Yes/No
Lip biting or sucking _____	Mouth breathing _____	Yes/No
Nail biting _____	Other habits _____	Yes/No
Musical Instruments _____	Snoring _____	Yes/No
Instrument _____		

Are there any problems not covered above? _____

Patient's attitude toward dental care:

Brushing teeth _____ Times per day _____ Rarely _____ Never
Dental checkups _____ Times per day _____ As needed _____ Never
Date of last dental checkup _____

Patient's interest in orthodontic care:

_____ Wants treatment _____ Unwilling, but agrees _____ Uncooperative

What do you perceive as the primary problem? _____

Chief concern: _____

Doctor's chief concerns: _____

SIGNATURE OF INDIVIDUAL COMPLETING FORM

Relationship to patient _____ Date _____

Thank you for your information. Please feel free to discuss any aspect of your care with us.

Dr. Steven A. LeBeau and Staff