

Patient Name _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential.

ADULT PATIENT PROFILE

Are you sensitive or self-conscious about your teeth? Yes No dk/u

DENTAL HISTORY

Please indicate your main concerns _____

Date of your last dental examination _____

Have you ever had orthodontic treatment? Yes No dk/u

Has an orthodontist been previously consulted? Yes No dk/u

Have you ever had any periodontal or gum problems? Yes No dk/u

Are you having pain or discomfort at this time? Yes No dk/u

Have there been injuries to the face, mouth, or teeth? Yes No dk/u

Have you been informed of any missing or extra permanent teeth? Yes No dk/u

Do you have any of the following habits?

Clenching/Grinding Thumb/Finger Sucking Tongue Thrust Mouth Breathing

What concerns you most about orthodontic treatment?

Appearance of appliances Cost Length of time Discomfort Results Other _____

MEDICAL HISTORY

Please describe your current health: Good Fair Poor

Please list all medications you are currently taking _____

Are you allergic to any drugs or medications? Please list _____

Have you ever had any of the following conditions? (please circle)

- | | | |
|--------------------------|--------------------|-----------------------|
| Heart Disease | Asthma | Epilepsy or Seizures |
| High Blood Pressure | Diabetes | Sleep Apnea |
| Heart Surgery | Thyroid Disease | Bone Disorders |
| Heart Murmur | Sinus Trouble | Growth Disorders |
| Rheumatic Fever | Pain in Jaw Joints | Allergies to Latex |
| Congenital Heart Lesions | Cancer | Allergies to Metals |
| Artificial Heart Valve | HIV/AIDS | Allergies to Plastics |
| Artificial Joint | Hepatitis | |
| Stroke | Bleeding Disorder | |

Do you have any disease, condition, or problem not listed? Please list _____

WOMEN: Are you pregnant now? Yes No

Do you anticipate becoming pregnant within the next few years? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If there are any changes in my health, I will inform the office at the next appointment without fail.

Date

Signature of Patient