Spurrier ORTHODONTICS

Name _____

ID No. _____

Youth Patient Dental History Information

1. What is the patient's main orthodontic concern as you see it? _____

2. Is the patient sensitive about the appearance of his/her teeth or facial features (nose, chin, lips, etc?) _____

3. Are you interested in Traditional Braces? _____

4. Have you consulted with an orthodontist previously? ☐ Yes ☐ No If yes, when? _____

5. Has anyone in the family received orthodontic treatment? ☐ Yes ☐ No

6. If yes, who? _____

7. Name of your current general dentist: _____

8. Name of previous general dentist: _____

9. Frequency of dental checkups? _____ Date of last dental exam: _____

10. Are there any needed dental restorations? ☐ Yes ☐ No

11. Date restorations will be completed? _____

Please check any of the following that apply and explain in the box below:

☐ 12. Are you apprehensive about dental care?
☐ 13. Have you had any trouble associated with dental treatment?
☐ 14. Have you had any teeth extracted?
☐ 15. Have you ever injured or broken any teeth?
☐ 16. Do you have any discomfort from your teeth?
☐ 17. Do you have any missing teeth?
☐ 18. Do you have any extra teeth?
☐ 19. Do you habitually grind or clench teeth?
☐ 20. Do you receive regular fluoride treatment?
☐ 21. Do you have periodontal or gum problems?
☐ 22. Do you have canker sores?
☐ 23. Are you aware of any swellings or growths in your mouth?
☐ 24. Do you breathe with your mouth open or lips parted?
☐ 25. Have you been referred to or are you being treated by a dental specialist? (i.e. oral surgeon, periodontist, endodontist)
☐ 26. Have you had any injuries to your face or mouth?
☐ 27. Have you had any injuries to either jaw?
☐ 28. Do you suck on your fingers or thumb?
☐ 29. Do you chew on other objects such as pens, ice, fingernails?
☐ 30. Do you have regular jaw pain?
☐ 31. Do you have limited jaw movement?
☐ 32. Do your jaws click or pop?
☐ 33. Do you have any trouble eating, chewing or swallowing?
☐ 34. Are you in speech therapy currently?
☐ 35. Have you been diagnosed with a tongue thrust?
☐ 36. Have you been treated for TMJ problems?

If you have checked any of the above, please explain:

Continued on Back

Youth Patient Medical History Information

Name & Location of Physician: _____ Is patient in Good Health: ☐ Yes ☐ No

Patient's Height: _____ Weight: _____ Has patient's shoe size changed recently? ☐ Yes ☐ No

Date of last physical: _____ Are you presently under the care of a physician for any illness? _____ Please specify below.

Do you have a history of major illness or been hospitalized? _____ Please specify below.

Is there anything you would like to talk to the doctor about in private? _____

Please check any of the following that apply to the patient and explain in the box below:

☐ 1. Have you seen a medical specialist for any reason?
☐ 2. Do you have a tendency to catch colds?
☐ 3. Do you have an allergy to latex?
☐ 4. Do you have an allergy to metals?
☐ 5. Do you have any drug allergies/sensitivities?
☐ 6. Do you have an allergy to dental anesthetics?
☐ 7. Do you require pre-medications prior to dental visits?
☐ 8. Are you taking any drugs or medications?
☐ 9. Have you ever received Bisphosphonate treatment or other bone building medications? (e.g. Fosamax, Actinol, Boniva)
☐ 10. Do you have gastric reflux?
☐ 11. If female, has menses occurred?
☐ 12. Do you smoke or use tobacco products?

Please check any of the following for which the patient has been treated and explain in the box below:

☐ 13. AIDS/HIV?
☐ 14. Asthma?
☐ 15. Arthritis?
☐ 16. Artificial joints?
☐ 17. Bone disorders?
☐ 18. Cancer?
☐ 19. Cerebral palsy?
☐ 20. Diabetes?
☐ 21. Mental Health or Depression?
☐ 22. Endocrine problems?
☐ 23. Epilepsy or Seizures?
☐ 24. Fainting or dizziness?
☐ 25. Frequent headaches or neck aches?
☐ 26. Heart trouble (i.e. congenital heart defect, murmurs)
☐ 27. Hepatitis?
☐ 28. Hormone therapy?
☐ 29. Jaundice?
☐ 30. Kidney problems?
☐ 31. Liver problems?
☐ 32. Low/high blood pressure?
☐ 33. Multiple sclerosis?
☐ 34. Nervous disorders?
☐ 35. Osteoporosis?
☐ 36. Prolonged bleeding?
☐ 37. Rheumatic fever?
☐ 38. Sickle cell anemia?
☐ 39. Sleep Apnea/Snoring?
☐ 40. Stomach ulcers?
☐ 41. Tuberculosis?
☐ 42. Thyroid problems?
☐ 43. Unusual growth patterns?

If you have checked any of the above, please explain:

I authorize the release of any neccessary dental or medical records to Spurrier Orthodontics for this patient. Records may be discussed with other health care providers and/or for educational purposes.

_____
Responsible Person

Dr. _____ Tech _____