

Griffin and Errera Orthodontics

Orthodontics for Children and Adults

General Information

Patient's Name _____ Nickname _____
 Address _____ City/State _____ Zip _____
 School _____ Grade _____ Date of Birth _____ Sex _____
 Phone (Home) _____ (Work) _____ Email _____
 Dentist _____ Referred by _____ Physician _____

Check Yes or No
 If yes, give details
 Under remarks

MEDICAL HISTORY OF PATIENT

Has there been any history of joint swelling, heart trouble, asthma, TB, kidney or liver ailment, epilepsy, rheumatic fever or other major illness? If so please circle each

Have you ever tested positive for hepatitis, HIV, or any blood disorders?

Is there a tendency to faint or become dizzy?

Are tonsils or adenoids present?

Do you bleed easily, or is bleeding hard to stop?

Are there any allergies? (Sulpha, penicillin, novacaine, others)

Are you under care of a physician at present?

Have any medical X-rays been taken in the past 6 months?

Have you ever experienced any pain or joint sounds around the Temporomandibular joints (Jaw Joints) ?.....

Do you suffer from frequent headaches?

Do they occur during any particular time of the day or night?

Are there any serious or re-occurring illnesses? If so please list _____

YES NO

DENTAL HISTORY OF PATIENT

Have there been many cavities in the past?

Have there been any injuries to the teeth? (falls, blows, chips, etc.)

Did any teeth abscess or cause gum boils?

Were any teeth removed by extraction?

Was it suggested that the space be maintained?

Was an appliance placed?

Do you breathe through the mouth, or are the lips parted?

Were there habits that might have caused the teeth to move, such as lip or nail biting, thumb sucking, etc?

Has an orthodontist been consulted previously?

Has anyone in the family had orthodontic treatment?

If so, by whom? _____

Has your dentist mentioned that you or other family members have periodontal disease or gingivitis?

By whom were last dental X-rays taken? _____ Date taken _____
 What would you most like to have orthodontic treatment accomplish? _____

Remarks: _____

Signature of Parent Requesting Care _____ Date _____

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