Reading Orthodontics

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Personal History Form - Child

Name ______________ Nick Name ______________ D.O.B.____/____/____ Age ____Y ____M
Address______________ City______________ State ______ Zip ______________
Home Phone______________ Cell Phone ______________
Email ______________School ______________ Grade ________
Physician ______________ Dentist ______________ Referred by ______________
Father's Name ______________Occupation ______________ Employed by ______________
Business Address ______________Phone ______________EXT ____
Mother's Name ______________Occupation ______________ Employed by ______________
Business Address ______________Phone ______________EXT ____
Name & Ages of Siblings ______________ Are Parents Divorced? ___Separated? ___ Widowed?___
Person Financially Responsible ______________ Relationship______________
Dental Insurance: YES NO Orthodontic Coverage: YES NO
Plan Name ______________Subscriber's SS# ______________Group #______________

Medical History (Please circle yes or no and fill in blanks where required)

1. Date of last medical exam ___________ Is patient in good health? YES NO
2. Have patients tonsils and/or adenoids been removed? At what age?______________ YES NO
3. Has patient reached puberty? YES NO
4. Are height and weight normal for age? YES NO
5. Frequent colds, sore throat, or ear infections? YES NO
6. Any history of major illness? If yes please list ______________ YES NO
7. Any allergy or drug sensitivity? If yes please list ______________ YES NO
8. Taking any medication now/ If yes please list______________ YES NO
9. Is the patient under medical? or psychological care now? Explain______________ YES NO
10. Circle any of the following for which the patient has been or is being treated:

Diabetes	Hepatitis	Pos. HIV Antibody	Heart Trouble	Drug Addiction
Arthritis	Cancer	Nervous Disorders	Brain injury	Blood Transfusion
Asthma	Herpes	Endocrine Problems	Tuberculosis	Rheumatic Fever
AIDS	Epilepsy	Thyroid Problems	Infectious Mono	Prolonged Bleeding
Tonsillitis	ARC	High Blood Pressure	Pregnancy	Low Blood Pressure

11. Does the patient have, or ever had any medical condition not mentioned above? YES NO

Dental History

1. Date of last dental exam ______________Full mouth X-rays taken? When?___________ YES NO
2. Have there been any injuries to the face, mouth or teeth? Describe ______________ YES NO
3. Has the patient ever sucked thumb or fingers? Until what age? ______________ YES NO
4. Any oral habits such as lip biting, tongue thrusting,finger sucking, or nail biting? YES NO
5. Has the patient ever had speech problems or speech therapy? YES NO
6. Is the patient a mouth breather while asleep or awake? YES NO
7. Has the patient ever had pain, clicking or popping of the jaw joints? Any TMJ Problems? YES NO
8. Has the patient seen an Orthodontist? If so Dr.'s name ______________ Records taken? YES NO
9. Have either parent or other children had orthodontic treatment? YES NO
10. Would you consider the patient's diet high in sweets? YES NO
11. Patient's attitude toward braces: Complacency ______ Eagerness ______ Resignation ______ Antagonism ______
12. List any musical instrument played ______________ Hours per day _________ Hobbies ______________
13. What orthodontic problems are you most concerned about? ______________
____
14. What problem is your dentist most concerned about? ______________
____

Person filling out this form please sign: Signature:______________ Date: ______________

CLINICAL EXAMINATION

EXAM DATE ____________________
Red

RE-EXAM DATE ________________
Blue

1. Profile: flat convex mild/mod/sev concave mild/mod/sev
2. Dentition: normal protruded retruded bimaxillary
3. Lips: normal parted overted full thin cleft repaired
4. Symmetry: chin centered deviates R L occ plane tipped Y N
5. Habits: TT MB LB Other ____________________
6. Hygiene: _______X per day P F G E fluoride rinse Y N
7. Soft Tissue: norm marg ging'tis NUG edema hyperplastic receded
8. Frenum: Maxillary norm enlarged mandibular norm enlarged
9. Questionable Lesions: None ____
10. Caries Rate: Low Mod High restorations needed ______|______
11. Teeth:

L - decalcified
F - fractured
R - caries
S - supernumerary
I - impacted
U - submerged
X - extracted
P - ectopic
M - cong. Missing
Y - atypical or malformed

8 1	7 2	6 3	5 4	4 5	3 6	2 7	1 8	1 9	2 10	3 11	4 12	5 13	6 14	7 15	8 16
32 8	31 7	30 6	29 5	28 4	27 3	26 2	25 1	24 1	23 2	22 3	21 4	20 5	19 6	18 7	17 8

12. Eruption time: normal early delayed
13. Prolonged retention of deciduous teeth: ________|________
14. Early Loss of teeth: ________|________
15. Migrated: mes ____|____ dist ________|________
16. Class I II div I II div 2 sub R L III mod sev

R	L

R	L

R	L

17. Overbite norm deep impinging _____% open ____mm
18. Overjet: ______________mm
19. Curve of Spec: flat mild mod severe tilted
20. Midline disastema _______mm max mand familial fornum
21. TMJ: norm click R L pain R L Lim' Mov'mnt Lim' opening
22. Path of closure: deviates to anterior posterior R L
23. Cross bite unilat R L bilat ant ________|________
24. Diharmony or arches: maxilla norm wide narrow
    mandible norm wide narrow
25. Midline ________|________
26. Crowding or rotations maxilla mandible ________|________
27. Swallow: norm teeth apart grimace mentalis activity
28. Other findings:
    Prelim diagnosis:

Recommendations:

____
____
____
____
____

Exam	Records	Est. Fee	Ext. Tx Time	Date Quoted

Date	Service	Time	Next Treatment	Date