TODAYS DATE: _____

PATIENT INFORMATION:

Name & Suffix: _____ **Prefers to be called:** _ _____

DOB: _ _____ **Age**: _____

Home Address: _____

Contact Phone: _____

Employer: _____ **Occupation:** _____

Email: _____

Marital Status: Married Divorced Separated Single Widowed

Spouse's Name: _____

DOCTOR INFORMATION: **Who is your dentist?** _____

ORTHODONTIC TREATMENT:

Have you had previous orthodontic treatment? _____ | Yes | No |

If yes, please explain:

_____

HEALTH INFORMATION:

Are you taking any medication regularly? _____ | Yes | No |

If so, please list: _____

Are you allergic to any food or drug? _____ | Yes | No |

If so, please list: _____

Do you have an illness/disease we should be aware of? _____ | Yes | No |

If so, please list: _____

Have you had accidents or injuries relating to your face, teeth, or head?	Yes	No
If so, please explain:		
Did you suck your thumb or fingers as a child?	Yes	No
Do you have any oral habits such as but not limited to nail biting, lip biting or cheek biting?	Yes	No
If so, please explain:		
Do you grind or clench their teeth?	Yes	No
Do you have any jaw pain when opening, chewing or yawning?	Yes	No
Do you have limited jaw movement?	Yes	No
Do you have clicking or popping noise in your ears while chewing?	Yes	No
Does your jaw get stuck open or closed?	Yes	No
Have you had any adult teeth extracted other than wisdom teeth?	Yes	No
If so, please explain:		

Signature: _____ **Date:**_____

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