Dr. Barry White - Orthodontist

Thank you for choosing our office for your Orthodontic care

Name _____ Dr.[ ] Mr.[ ] Mrs.[ ] Miss[ ] Ms.[ ] Other _____

Address _____ Apt. No. _____ City _____

Home Telephone _____ Business Telephone _____ Ext _____ Postal Code _____

Business Address _____

Email: _____

Date of Birth _____

Dentist _____ Physician _____ Medical Specialist _____

When was your last dental visit? _____ What was done at that visit? _____

How did you find out about our office? _____

	Yes	No	Unsure
Is there a history in your family of irregular/protruding teeth? _____	[ ]	[ ]	[ ]
Is there a history in your family of congenitally missing teeth? _____	[ ]	[ ]	[ ]
Has any other member of your family had orthodontic treatment? _____	[ ]	[ ]	[ ]
Is your orthodontic problem obvious to you? _____	[ ]	[ ]	[ ]
Are you satisfied with the appearance of your teeth? _____	[ ]	[ ]	[ ]
Have you had any severe accidents involving your teeth, jaws, lips? _____	[ ]	[ ]	[ ]
Do you have frequent sore throats? _____	[ ]	[ ]	[ ]
Do you have any allergies? _____	[ ]	[ ]	[ ]
If yes, please describe _____			
Do you often breathe through your mouth? _____	[ ]	[ ]	[ ]
Have you had any teeth extracted for any reason? _____	[ ]	[ ]	[ ]
Do you have or have you ever had gum disease? _____	[ ]	[ ]	[ ]
Do you smoke currently or have you smoked in the past? _____ # of Years? _____	[ ]	[ ]	[ ]
Have you had any previous orthodontic consultations or treatment? _____	[ ]	[ ]	[ ]
Do you have any emotional concerns re: dental treatment? _____	[ ]	[ ]	[ ]
Are you in good general health? _____	[ ]	[ ]	[ ]
Have you had any serious illness? If yes, what _____	[ ]	[ ]	[ ]
Are you currently taking any medication? _____	[ ]	[ ]	[ ]
(If yes, what? _____)			
Have you ever received antibiotic premedication for dental appointments? _____	[ ]	[ ]	[ ]
Are you currently under the care of a physician for any reason? _____	[ ]	[ ]	[ ]

Please circle if you have or ever have had any of the following conditions.

-Heart murmur	-Cancer	-Hepatitis	-Rheumatic/Scarlet fever
-Artificial heart valve	-Asthma	-HIV	-Epilepsy
-Any heart problem	-Diabetes	-Fainting	-Blood disorder
-Organ transplant	- Artificial joints (hip, knee, other)		-High blood pressure

Are there any other conditions or diseases not listed above that you have or have had? If so, what? _____

Signature of Patient _____ Date _____