SARAH B. LOWE, D.D.S., P.A.

Orthodontics / Preliminary Information

Date_____

Patient's name _____ Email_____

Birthday _____ Age _____

School _____ Grade_____

Other Children in Family: Number _____ Ages _____

Musical Inst. _____

Parents or Guardian _____ TDL # _____

Occupation _____ Employed by _____

Res. Address _____ Res. Phone _____

City _____ Email_____

Bus. Address _____ Bus. Phone _____

City _____

Subject to transfer? _____ Comments _____

General Dentist _____ Last Cleaning _____

Physician _____

Whom may we thank for this referral? _____

Signature of Responsible Party: _____

DENTAL HISTORY

Y N

- ☐ ☐ Has patient ever sucked thumb or fingers? Until what age? _____
- ☐ ☐ Does patient breathe predominantly through the mouth?
- ☐ ☐ Does patient have any speech problems?
- ☐ ☐ Does patient have any noticeable difficulty in chewing/swallowing food?
- ☐ ☐ Does patient clench or grind teeth during day or night?
- ☐ ☐ Does patient have pain or clicking upon opening or closing mouth?
- ☐ ☐ Does patient notice bleeding of gums spontaneously or while brushing?
- ☐ ☐ Has patient had any sever head or face injuries?
- ☐ ☐ Have any teeth been injured/chipped due to accidents?
  When? _____
- ☐ ☐ Has patient ever had any abscessed teeth?
- ☐ ☐ Have you been informed of any missing permanent teeth?
- ☐ ☐ Have you been informed of any extra teeth?
- ☐ ☐ Were any teeth (baby or permanent) removed by extraction?
- ☐ ☐ Was it suggested that the space be maintained?
- ☐ ☐ Was an appliance placed to maintain the space?
- ☐ ☐ Is the patient taking fluoride drops, pills or fluoridated water?
- ☐ ☐ Have the teeth been treated with fluorides?
- ☐ ☐ Does the patient see the dentist regularly?
  Date of last appointment _____
- ☐ ☐ Does anyone in the family have a similar condition?
  Who? _____
- ☐ ☐ Would patient mind wearing "braces" (bands)?
- ☐ ☐ Has any member of the family had orthodontic treatment?
  Who? _____
  How often does patient brush teeth? _____
  Who first noticed need for orthodontic treatment?
  ☐ Dentist ☐ Patient ☐ Friend ☐ Relative When? _____

Patient/Parent Signature _____

Dr. Signature _____

MEDICAL HISTORY

Y N

Date of last physical examination _____
given by _____

- ☐ ☐ Is patient presently under a physicians care? For what? _____
- ☐ ☐ Has patient ever had any reaction to drugs/medication?
  What? _____
- ☐ ☐ Is patient receiving any drugs/medication presently? What? _____
- ☐ ☐ Has patient ever had any major surgery or been hospitalized?
  For what condition? _____
- ☐ ☐ Does patient have any allergies? List _____
- ☐ ☐ Has patient ever had any broken bones? Were there any problems in healing? _____
- ☐ ☐ Does patient have frequent (underline) breathing problems, sinus congestion, cold, sore throats, ear infections?
- ☐ ☐ Have patient's tonsils and/or adenoids been removed?
  Age _____

Check any of the following disease for which patient has been treated:

☐ Measles	☐ Thyroid	☐ Heart Trouble	☐ Cerebral Palsy
☐ Chickenpox	☐ Wooping cough	☐ Arthritis	☐ Bone Disorders
☐ Mumps	☐ Pneumonia	☐ Rheumatic Fever	☐ Prolonged Bleeding
☐ Scarlet Fever	☐ Tonsillitis	☐ Epilepsy	☐ Emotional Problem
☐ Anemia	☐ High Fever	☐ Polio	☐ Endocrine Problem
☐ Diptheria	☐ Tuberculosis	☐ Diabetes	☐ Nutritional Problem
			☐ Fainting/Dizziness

- ☐ ☐ Does patient have a chronic kidney ☐ heart ☐ liver ☐ blood ☐ problem?
- ☐ ☐ Were there any unusual circumstances with any of the childhood diseases?
  Explain: _____
  Any other pertinent medical problems? Describe _____
- ☐ ☐ Hepatitis
- ☐ ☐ HIV +
- ☐ ☐ Artificial Prosthesis
- ☐ ☐ Are you pregnant or think you might be?

PATIENT'S NAME:_____ PATIENT'S #_____ DATE:_____

DOCTOR:_____

CLASSIFICATION: Class I
Class II Div I Subdivision
Class II Div. II
Class III

CARIES : Excessive
Moderate
Slight
None

OVERJET_____ mm.

ORAL HYGIENE: Good
Fair
Poor

OVERBITE: Open
Deep
Moderate
Slight

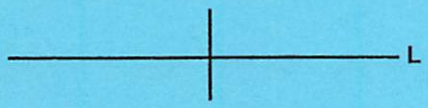
HABITS: Mentalis
Thumbsucker
Tongue Thrust
Mouth Breather
Other_____

CROWDING: U_____
L_____

MIDLINE_____ mm. R or L

MISSING TEETH

MOLAR CUSPID



IMPACTED

PALATE: Narrow
Wide
Normal

MANDIBLE: Narrow
Wide
Normal

SUPERNUMARARY

RECALL: 3 mos 6 mos
12 mos 2 yrs

NON-EXTRACTION

Blood Pressure_____ **Pulse**_____

Sibling _____

Insurance _____

EXTRACTIONS

ADDITIONAL NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

BitePlate Today_____

Seps Today_____

Nance Appl _____

RPE Appl _____

Consultation_____

1.Smile at rest

2. Smile Max

3.Gingival Exposure

4. Tooth HT*width.80

5. GoldenProp 1.6,1.0,.6