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

Orthodontics / Preliminary Information Date _____

Patient's Name _____ Email _____

Birthday _____ Age _____

Address _____ City _____ Zip _____

School _____ Grade _____

Parents/Guardian _____ PHONE#
(If patient is a minor)

Email: _____ Email: _____
Mother Father

Other Children in family: Number _____

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 severe head or face injuries?
- ☐ ☐ Have any teeth beenlured/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? _____

How often does patient brush teeth?

Who first noticed need for orthodontic treatment?

☐Dentist ☐Patient ☐Friend ☐Relative When? _____

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:

☐ Measels	☐ Thyroid	☐ Heart Trouble	☐ Cerebral Palsy
☐ Chickenpox	☐ Whooping Cough	☐ Arthritis	☐ Bone Disorders
☐ Mumps	☐ Pneumonia	☐ Rheumatic Fever	☐ Prolonged Bleeding
☐ Scarlet Fever	☐ Tonsilitis	☐ Epilepsy	☐ Emotional Problem
☐ Anemia	☐ High Fever	☐ Polio	☐ Endocrine Problem
☐ Dyptheria	☐ 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 _____ **DATE** _____

DOCTOR _____

CLASSIFICATION: Class I
Class II Div I · Subdivision
Class II Div. 2
Class III

CARIES: Excessive
Moderate
Slight
None

OVERJET _____ mm.

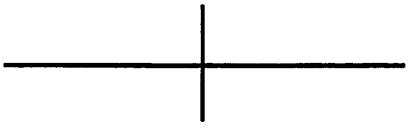
ORAL HYGIENE: Good
Fair
Poor

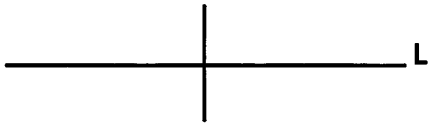
OVERBITE: Open
Deep
Moderate
Slight

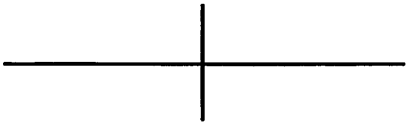
HABITS: Mentalis
Thumbsucker
Tongue Thrust
Mouth Breather
Other _____

CROWDING: U _____
L _____

MIDLINE _____ mm. R or L

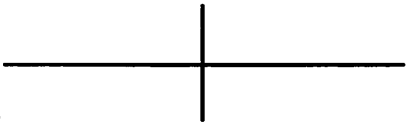
MISSING TEETH R  L

MOLAR
CUSPID R  L

IMPACTED R  L

PALATE: Narrow
Wide
Normal

MANDIBLE: Narrow
Wide
Normal

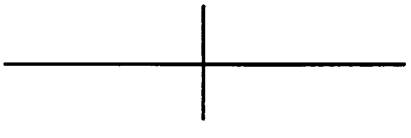
SUPERNUMARARY R  L

RECALL: 3 mos 6 mos
12 mos 2 yrs

NON-EXTRACTION

Blood Pressure _____ **Pulse** _____

Sibling _____

EXTRACTION R  L

Insurance _____

ADDITIONAL NOTES: