DENTAL HISTORY

- YOUR MAIN REASON FOR THIS CONSULTATION? _____

_____

- WHOM MAY WE THANK FOR RECOMMENDING US? _____

_____

- PATIENT'S LAST DENTAL APPOINTMENT? (month, year) _____

- ANY PREVIOUS INJURIES TO HEAD, FACE, MOUTH, TEETH? YES NO

If yes, can you describe the injury? _____

_____

- IS THERE A HISTORY OF THUMB OR FINGERSUCKING? YES NO

If yes to the above question, until what age? _____

- ARE THERE ANY SPEECH PROBLEMS? YES NO

- HAVE YOU BEEN INFORMED OF ANY MISSING TEETH? YES NO

- HAVE YOU BEEN INFORMED OF ANY EXTRA TEETH PRESENT? YES NO

- HAVE ANY PERMANENT TEETH BEEN REMOVED? YES NO

If yes, for what reason? _____

- IS THERE ANY DIFFICULTY WITH CHEWING, SWALLOWING? YES NO

- ANY HISTORY OF CLENCHING, GRINDING? YES NO

- PREVIOUS HISTORY OF ORTHODONTIC TREATMENT? YES NO

If yes, full braces?, retainers?, other treatment?

- HAS THERE BEEN AN ORTHODONTIC CONSULTATION BEFORE? YES NO

- WHAT CONCERNS YOU MOST ABOUT ORTHODONTICS? _____

_____

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- HOBBIES, MUSICAL INSTRUMENTS, INTERESTS? _____

_____

- OTHER INFORMATION YOU FEEL IS PERTINENT? _____

_____

_____

ACQUAINTANCE FORM PAGE 2

- YOUR MAIN REASON FOR THIS CONSULTATION?_____

_____

- WHOM MAY WE THANK FOR RECOMMENDING US? _____

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