Woodlands Village Braces

☐ EXAM
☐ MONTHS IN TX
☐ BRACES BEFORE
☐ PX & TX NEEDED

Patient Name:

Last _____ First _____

(M.I.) ____ ☐ M ☐ F Date of Birth _____ Age _____

Parent Name:

Last _____ First _____

How did you hear about our office? _____

Home Address _____ City _____ State _____ Zip _____

Cell Phone _____ Other Phone _____ Privacy permission given to _____

Emergency Contact _____ Relationship _____ Telephone _____

If Applicable: Who's accompanying the child today? _____ Circle if you do not have legal custody of this child: N

Person responsible for account _____ Occupation _____ Relationship _____

Email

Who is your general dentist? _____ Telephone _____

Last Visit _____ Who else has examined you? _____

PATIENT MEDICAL AND DENTAL HISTORY • *CIRCLE ALL THAT APPLY*

Women: pregnant, nursing? Yes / No **Are you allergic to**: Any metal, plastics, latex? Yes / No other: _____

Have you ever had: jaw pain, jaw lock (couldn't open or close), jaw popping or clicking, injury to the face or head, ear pain, severe headaches, blood disorder, Diabetes, Hepatitis A or B or C, HIV or AIDS or ARC, an STD, high or low blood pressure, kidney problems, liver disease, organ transplants, artificial joints or bones, Hemophilia, heart murmur, heart surgery, heart attack or stroke, pacemaker, Epilepsy, Tuberculosis, congenital defect, radiation therapy, paralysis, transfusion, cancer, chemotherapy, psychiatric problems or depression, brain disorder, other surgeries or hospitalizations? Yes / No

Other: _____ **Do you need to be pre-medicated**? Yes / No **Your health is**: Good / Poor

Do you take any prescription drugs? Yes / No **Which ones?** _____

Bad experience whitening your teeth? Yes / No **Are you allergic to**: Aspirin, Dental Anesthetics, Penicillin, Erythromycin, Tetracycline, Codeine? Yes / No

Do you grind your teeth? Yes / No **Do you have any speech problems?** Yes / No **Have you ever had**: Anemia, Arthritis, Asthma, difficulty breathing, Emphysema, fainting, fever blisters, recurrent infections, Rheumatism, Shingles, sinus problems, ulcers, venereal disease, weight change, mouth infection, gum disease? Yes / No **Do you sleep well regularly?** Yes / No **Do you breathe usually through your nose?** Yes / No

Have you had braces before? Yes / No **Are you in braces now?** Yes / No **Have you had deep cleanings?** Yes / No **Sleep Apnea?** Yes / No

Snore? Yes / No **TMJ Pain?** Yes / No

By signing here, I confirm that the information that I have given today is correct to the best of my knowledge.

_____ _____ _____

Signature (patient / guardian) Date Please print your name

Our office offers Orthodontic and General Dentistry services. If you don't have a dentist we can be your dentist.

☐ PROPHY ☐ XRAYS ☐ PREVENTIVE ☐ RESTORATIVE ☐ COSMETIC

History / DX _____

_____

_____

Not to be treated _____

Concerns Prior to Tx _____

Tx Accepted ☐ Yes ☐ No Records ☐ Yes ☐ No Appt Made _____

Follow up with _____, ☐ Call ☐ Text ☐ Email