Dr. Cecil B. Sharp Inc.
Certified Specialist in Orthodontics

GENERAL INFORMATION

Appt. Date:.....

Patient's name:..... Preferred name: .....
Birthdate: ..... Age:..... Sex: .....
Address: .....
Postal code: ..... Telephone: .....
Dentist: ..... Physician:.....
Whom can we thank for referring you to see us?. .....
Employer and
address.....
Occupation: ..... Work Phone:.....
Individual responsible for account: .....
Email:.....

Spouse's name: .....
Occupation: ..... Work Phone:.....
Employer and address: .....

Do you have orthodontic insurance? ..... Insurance company: .....
Name of Subscriber: ..... Subscriber Birthdate: .. ..
Relationship to patient:.....
Address (if different from above):.....
Group policy: ..... Certificate no.:.....
S.I.N. or Identity no.: ..... Dependant no.: .....

GENERAL HEALTH QUESTIONNAIRE

Please indicate if the patient is affected by any of the following conditions.

__Diabetes
__Asthma or other respiratory condition
__Rheumatic fever
__Convulsions
__Kidney disease
__Heart disease
__Bone disorders
__Tuberculosis
__Fainting and / or dizziness
__Frequent headaches and / or neck aches
__Chronic illness
__Ever been hospitalized
__Anemia
__Bleeding problems
__Liver disease / hepatitis
__Nervous disorders
__Frequent cold sores or canker sores
__Shortness of breath or chest pains
__High blood pressure
__Cancer
__AIDS
__Arthritis
__Birth defects
__Breathes mainly through mouth
__Tendency to colds, sore throats, or ear infections (please circle)
__Removal of tonsils and adenoids. What age? ____
__Allergies or drug sensitivities.
Specify .....
__Taking medications now. Specify .....

ORTHODONTIC PATIENT HISTORY

Please indicate which of the following, if any, are cause of concern relating to this orthodontic consultation.

__Protruding teeth
__Crowded teeth
__Spaces teeth
__Missing teeth
__Irregularly placed teeth
__Appearance of lips / mouth
__Shows too much gum tissue
__Teeth erupting in wrong position
__Lip biting or sucking
__Grinding or clenching teeth
__Some teeth have not erupted
__Impacted teeth
__Deep overbite
__Open bite (front teeth don't overlap)
__Underbite (protruding lower jaw)
__Crossbite
__Cleft lip and / or palate
__Tongue thrust (abnormal swallow)
__Thumb or finger sucking
__Nail biting
__Speech problems
__Other.....
__Difficulties in opening wide, chewing, or swallowing (please circle)
__Clicking noises or pain when opening or closing mouth
__Major fall, accident or operation affecting the teeth or mouth
(explain):.....
.....
__History of major illness. Explain
.....
.....

	Yes	No	
a)	__	__	Has patient had a previous orthodontic examination?
b)	__	__	Does anyone in the family have orthodontic problems?
c)	__	__	Has anyone in the family had orthodontic treatment?
d)	__	__	Is the patient receptive to having orthodontic treatment?
e)	__	__	Does the patient have regular dental care?
f)	__	__	Has the patient had any teeth removed?
g)	__	__	Does the patient play any musical instruments involving the mouth?
h)	__	__	Does the patient wear anything removable in the mouth?
i)	__	__	Women -- are you pregnant? Due date: .....

Please elaborate on any replies below.
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.....
.....
.....

Information may be exchanged between dental offices and insurance companies in order to provide you with the best possible dental care.

SIGNATURE .....

Payment is due as treatment is rendered unless prior arrangements are made.