



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

GENERAL INFORMATION

Appointment. 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?.....

School: Grade:

Father's name: Mothers name:

Occupation:..... Occupation:

Employed by:..... Employed by:.....

Telephone:..... Telephone:

Individual responsible for account:

Email:.....

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.: Dependent no.:.....

GENERAL HEALTH QUESTIONNAIRE

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

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma or other respiratory condition | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Liver disease / hepatitis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Frequent cold sores or canker sores |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Shortness of breath or chest pains |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fainting and / or dizziness | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Frequent headaches and / or neck aches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Ever been hospitalized | <input type="checkbox"/> Breathes mainly through mouth |
| <input type="checkbox"/> Tendency to colds, sore throats, or ear infections (please circle) | |
| <input type="checkbox"/> Removal of tonsils and adenoids. What age? ____ | |
| <input type="checkbox"/> Allergies or drug sensitivities. Specify:..... | |
| <input type="checkbox"/> 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
- Impacted teeth
- Crowded teeth
- Deep overbite
- Spaces teeth
- Open bite (front teeth don't overlap)
- Missing teeth
- Underbite (protruding lower jaw)
- Irregularly placed teeth
- Crossbite
- Appearance of lips / mouth
- Cleft lip and / or palate
- Shows too much gum tissue
- Tongue thrust (abnormal swallow)
- Teeth erupting in wrong position
- Thumb or finger sucking
- Lip biting or sucking
- Nail biting
- Grinding or clenching teeth
- Speech problems
- Some teeth have not erupted
- Other

Difficulties in opening wide, chewing, or swallowing

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:.....

How often does patient brush his / her teeth?

- | | 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? |
| h) | | | Does the patient wear anything removable in the mouth? |
| i) | | | Has the patient reached puberty yet? |
| j) | | | Women: are you pregnant? Due date: |

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

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

SIGNATURE (legal guardian if patient is under 18)
.....

Relationship to patient (if patient is under 18)

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