PARKER COUNTY ORTHODONTICS
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DENTAL HISTORY

PLEASE PRINT and USE BLACK or BLUE INK

Patient Name: _____ Date of Birth: _____
Last First Middle

General Dentist: _____
Name City Area Code + Phone Date of Last CLEANING

Why are you seeking orthodontic care? _____

How would you currently rate your smile? (circle one) Worst 1 2 3 4 5 6 7 8 9 10 Best

Please list any concerns you have about braces: _____

Other family members seen by our office: _____

How often do you brush? _____ How often do you floss? _____

Please ***CIRCLE*** the appropriate answers.

Do you CURRENTLY have any of the following habits?

Lip Sucking/Biting	Yes	No
Thumb/Finger Sucking	Yes	No
Nail Biting	Yes	No
Teeth Grinding	Yes	No
Mouth Breathing	Yes	No
Do you have any ringing in the ears?	Yes	No

If yes, how often?

_____

Do you have any jaw joint problems such as soreness, clicking, locking or popping? Yes No

If yes, how often?

_____

Have you had ANY injuries (minor or severe) to the head, neck, face or teeth, or been involved in any type of accident, e.g. car, athletic, etc.? Yes No

If yes, please explain: _____

_____

_____

Do you have any family history of headaches or migraines? Yes No

Do you have frequent headaches? Yes No

If yes, how often? _____

If yes, do you have any type of aura? Yes No

If yes, what is it? _____

FOR PATIENTS UNDER 12 YEARS OF AGE

How old were you when you lost your first tooth? _____

Do you lose baby teeth easily? Yes No

Is there any family history of missing or extra teeth? Yes No

If yes, please explain: _____

_____

_____

MY SIGNATURE BELOW INDICATES THAT I HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Signature: _____
(Parent, Legal Guardian, or Patient only)

Date: _____ D-2: _____

DI1: _____ DI2: _____