Wood Orthodontics - Steven C. Wood, DDS, MS
971 Hilltop Drive – Weatherford, TX 76086 – 817.599.5084

DENTAL HISTORY

PLEASE PRINT and USE 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? _____

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 / Clenching	Yes	No
Mouth Breathing	Yes	No
Chewing / Eating problems	Yes	No

Have you had any type of surgery involving the mouth, teeth, nose, sinuses or any part of the airway? Yes No

If yes, please explain: _____

_____

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

If yes, how often?

_____

Have you ever taken ANY bisphosphonate medications? (e.g., Fosamax, Boniva, Aredia) Yes No

If yes, please explain?

_____

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Have you had ANY bumps, bruises, cuts, or any type of injury (minor or severe) to the head, neck, face or teeth, or been involved in any type of accident, e.g. car, athletic, etc. resulting in ANY bodily injury? 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? _____

Do you have any ringing in the ears? Yes No

If yes, how often?

_____

Do you have frequent mouth ulcers or fever blisters? Yes No

FOR PATIENTS UNDER 13 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 Adult Patient only)

Date 1: _____ Date 2: _____