DR. PAUL A. WITT, INC.

CERTIFIED SPECIALIST IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

Date: _____

#_____

Patient's Last Name: _____ **Patient's First Name**: _____

Middle Name/Initials: _____ Prefers to be Called: _____

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female Email: _____

Patient's Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Occupation/School: _____ Grade: _____

Musical Instruments Played: _____ Sports and/or Hobbies: _____

Number of Siblings: _____ Ages: _____

Other Family Members Treated Here: _____

Patient's Dentist: _____

Dentist's Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Regular Dental Check-ups: ☐ yes ☐ no

Date Last Seen: _____ Reason: _____

Patient's Physician: _____

Physician's Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____

Date Last Seen: _____ Reason: _____

Custodial Parent or Guardian:_____

Relationship to Patient: _____

Address ☐ Same as Patient, or:

_____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Cell: _____ Work Phone: _____

Email: _____

Employer: _____

Custodial Parent or Guardian: _____

Relationship to Patient: _____

Address: ☐ Same as Patient, or:

_____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Cell: _____ Work Phone: _____

Email: _____

Employer: _____

Person Financially Responsible for this Account

Last Name: _____ First Name: _____

Middle Name/Initial: _____

Address ☐ Same as Patient, or:

_____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____

Cell: _____ Work Phone: _____

Email: _____

Years at this address: _____

Employer: _____

Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: _____

Birth Date: _____

Employed by: _____

Dental Insurance Company: _____

Group Number: _____

Secondary Policy Holder's Name: _____

Birth Date: _____

Employed by: _____

Dental Insurance Company: _____

Group Number: _____

Who suggested that the patient may require orthodontic treatment? ☐ Dentist or _____

Who may we thank for your referral? ☐ Dentist or _____

Why did you select our office? ☐ Dentist or _____

What is your primary concern? _____

Patient's Last Name: _____ Patient's First Name: _____ #_____

For the following questions mark 'yes', 'no', or 'don't know/understand' (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

Does the patient have any of the following:

Problems following instructions? ☐yes ☐no ☐dk/u
Learning disabilities? ☐yes ☐no ☐dk/u
Needs extra help with instructions? ☐yes ☐no ☐dk/u
Problems brushing his/her teeth thoroughly? ☐yes ☐no ☐dk/u
Sensitivity/self consciousness about his/her teeth? ☐yes ☐no ☐dk/u

☐ Patient resembles birth mother _____ birth mother's height
☐ Patient resembles birth father _____ birth father's height
☐ Patient resembles neither parent _____ patient's height

MEDICAL HISTORY

Date of most recent physical exam: _____

Now or in the past, has the patient had:

Birth defects or hereditary problems? ☐yes ☐no ☐dk/u
Bone fractures, major accidents, head injuries? ☐yes ☐no ☐dk/u
Rheumatoid, arthritic, or bone conditions? ☐yes ☐no ☐dk/u
Endocrine or thyroid problems? ☐yes ☐no ☐dk/u
Diabetes? ☐yes ☐no ☐dk/u
Kidney problems? ☐yes ☐no ☐dk/u
Cancer, tumour, radiotherapy or chemotherapy? ☐yes ☐no ☐dk/u
Polio, mononucleosis, tuberculosis, pneumonia? ☐yes ☐no ☐dk/u
Hepatitis A/B/C/D, jaundice, or liver problems? ☐yes ☐no ☐dk/u
AIDS or an HIV positive test result? ☐yes ☐no ☐dk/u
Problems of the immune system? ☐yes ☐no ☐dk/u
Fainting spells, seizures, epilepsy or other neurological problems? ☐yes ☐no ☐dk/u
Mental health disturbance or behavioural problem? ☐yes ☐no ☐dk/u
Substance abuse problems? ☐yes ☐no ☐dk/u
Vision, hearing, tasting, or speech difficulty? ☐yes ☐no ☐dk/u
Recent weight loss, poor appetite ☐yes ☐no ☐dk/u
Stomach ulcer, hyperacidity, or reflux? ☐yes ☐no ☐dk/u
History of eating disorder (anorexia, bulimia)? ☐yes ☐no ☐dk/u
Excessive bleeding or bruising tendency, anaemia, or bleeding disorder? ☐yes ☐no ☐dk/u
High or low blood pressure? ☐yes ☐no ☐dk/u
Tires easily? ☐yes ☐no ☐dk/u
Chest pain, shortness of breath or swelling ankles? ☐yes ☐no ☐dk/u
Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, congenital heart defects, heart murmur, or rheumatic heart disease)? ☐yes ☐no ☐dk/u
Skin disorder? ☐yes ☐no ☐dk/u
Hayfever, asthma, sinus trouble, or hives? ☐yes ☐no ☐dk/u
Frequent headaches, colds, sore throats, or ear infections? ☐yes ☐no ☐dk/u
Eye, ear, nose, or throat condition? ☐yes ☐no ☐dk/u
Tonsil or adenoid conditions? ☐yes ☐no ☐dk/u
Adenoids removed? If yes, date: _____ ☐yes ☐no ☐dk/u
Tonsils removed? If yes, date: _____ ☐yes ☐no ☐dk/u
Chewing tobacco or smoking habit? ☐yes ☐no ☐dk/u
Does the patient eat a well-balanced diet? ☐yes ☐no ☐dk/u
Other physical problems, symptoms, conditions? ☐yes ☐no ☐dk/u
If yes, describe: _____
Operations? ☐yes ☐no ☐dk/u
For: _____
Hospitalizations? ☐yes ☐no ☐dk/u
For: _____
Treatment by another health care professional? ☐yes ☐no ☐dk/u
For: _____

Is the patient taking <u>any</u> prescription medications, nutrient supplements, herbal medications, or non-prescription medicine? ☐yes ☐no ☐dk/u

Please list them:
Medication: _____ taken for _____
Medication: _____ taken for _____
Medication: _____ taken for _____

Allergies or reactions to any of the following:

Local Anesthetics (Novocaine or Lidocaine) ☐yes ☐no ☐dk/u
Aspirin ☐yes ☐no ☐dk/u
Ibuprofen (Motrin, Advil) ☐yes ☐no ☐dk/u
Penicillin or other antibiotics ☐yes ☐no ☐dk/u
Metals (jewellery, clothing snaps) ☐yes ☐no ☐dk/u
Latex (gloves, balloons) ☐yes ☐no ☐dk/u
Vinyl ☐yes ☐no ☐dk/u
Acrylic ☐yes ☐no ☐dk/u
Animals ☐yes ☐no ☐dk/u
Foods (specify) _____ ☐yes ☐no ☐dk/u
Other substances (specify) _____ ☐yes ☐no ☐dk/u

If the patient is female:

Has the patient started her monthly periods? ☐yes ☐no ☐dk/u
If so, approximately when? _____
Is the patient pregnant? ☐yes ☐no ☐dk/u
If so, approximate due date? _____

If the patient is male:

Has the patient's voice changed? ☐yes ☐no ☐dk/u
If so, approximately when? _____

FAMILY MEDICAL HISTORY

Do the patient's *parents or siblings* have any of the following health problems, and if so, please explain.

Bleeding disorders ☐no _____

Diabetes ☐no _____

Arthritis ☐no _____

Metabolic disturbances ☐no _____

Severe allergies ☐no _____

Unusual dental problems ☐no _____

Jaw size imbalance ☐no _____

Any other family medical conditions that we should know about? ☐no _____

DENTAL HISTORY

How often does the patient brush? _____ Floss? _____

Does the patient have, or has the patient had:

Primary (baby) teeth removed that were not loose? ☐yes ☐no ☐dk/u

Permanent or "extra" (supernumerary) teeth removed? ☐yes ☐no ☐dk/u

"Extra" (supernumerary) or congenitally missing teeth? ☐yes ☐no ☐dk/u

Chipped or otherwise injured primary (baby) or permanent teeth? ☐yes ☐no ☐dk/u

Teeth sensitive to hot or cold; teeth throb,or ache? ☐yes ☐no ☐dk/u

Jaw fractures, cysts, or mouth infections? ☐yes ☐no ☐dk/u

"Dead teeth" or root canals treated? ☐yes ☐no ☐dk/u

Abscesses, ("gum boils"), frequent canker sores, or cold sores? ☐yes ☐no ☐dk/u

Bleeding gums, bad taste or odour of the mouth? ☐yes ☐no ☐dk/u

Periodontal (gum) problems? ☐yes ☐no ☐dk/u

Any periodontal (gum) treatments? ☐yes ☐no ☐dk/u

Food sticking (impacting) between teeth? ☐yes ☐no ☐dk/u

Snacks often between meals? ☐yes ☐no ☐dk/u

What type? _____

History of speech problems? ☐yes ☐no ☐dk/u

Thumb or finger sucking habit, nail biting habit? ☐yes ☐no ☐dk/u

If yes, until what age? _____

Mouth breathing habit, snoring, or difficulty breathing? ☐yes ☐no ☐dk/u

Habitual leaning on chin or face? ☐yes ☐no ☐dk/u

Tooth grinding; jaw clenching, clicking or locking? ☐yes ☐no ☐dk/u

Any pain in jaw or ringing in the ears? ☐yes ☐no ☐dk/u

Any pain or soreness in the muscles of the face or around the ears? ☐yes ☐no ☐dk/u

Difficulty encountered in chewing or jaw opening? ☐yes ☐no ☐dk/u

Any relative with similar tooth or jaw problems? ☐yes ☐no ☐dk/u

Any form of fluoride supplements? ☐yes ☐no ☐dk/u

Any anxiety towards dental or medical procedures? ☐yes ☐no ☐dk/u

Any serious trouble associated with any previous dental treatment? ☐yes ☐no ☐dk/u

If yes, where and when? _____

Any prior orthodontic examination or treatment? ☐yes ☐no ☐dk/u

If yes, where and when? _____

Any objections to orthodontic appliances (braces) should they be indicated? ☐yes ☐no ☐dk/u

Any parent with prior orthodontic treatment? ☐yes ☐no ☐dk/u

If yes, where and when? _____

Any prior care under another dental specialist? ☐yes ☐no ☐dk/u

If yes, where and when?: _____

I have read and understand the above questions. I will not hold Dr. Witt or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date: _____
(Patient; Parent or Guardian if Patient is under 18)

Signed: _____ Date: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date: _____
(Patient; Parent or Guardian if Patient is under 18)

Signed: _____ Date: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date: _____
(Patient; Parent or Guardian if Patient is under 18)

Signed: _____ Date: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

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(Dental Staff Member)