



# 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 any 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: \_\_\_\_\_

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY UPDATE OR CHANGES**

Comments: \_\_\_\_\_

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Dental Staff Member)