HARBORCREEK DENTAL

PATIENT ORTHODONTIC INFORMATION FORM

Patient Name _____ **Age** _____

Dental History

	Yes	No
Who is the patient's general dentist? _____		
Have the patient's wisdom teeth been removed?		
Have there been any injuries to the patient's face, mouth, or teeth?		
Does the patient have any speech problems?		
Has the patient ever had a thumb, finger or sucking habit?		
If yes, until what age? _____		
Is the patient a mouth breather?		
Have you been informed of the patient having any missing or extra Permanent teeth?		
Does the patient have frequent cold or canker sores?		
Has the patient had any clicking or discomfort in the jaw joints?		
Does the patient grind or clench his/her teeth?		
Has the patient ever had a prior orthodontic examination or treatment?		

How often does the patient brush? _____ Floss? _____

When did the patient last have dental care? _____

When is the next scheduled visit? _____

What would you like to have orthodontic treatment accomplish?

_____

_____

_____ _____

Parent/Guardian's Signature **Date**

PLEASE DO NOT WRITE BELOW THIS LINE

Date	**Examination**	**Recommendation**
_____	Dentition:	_____
	Permanent ☐	_____
	Mixed ☐	_____
_____		_____
	CL _____	
	OJ _____	
	OB _____	
	Other _____	Estimated Length of tx: _____