Kevin Dunlavey, D.M.D., M.S., Orthodontist

PATIENT ORTHODONTIC INFORMATION FORM

Patient Name ____________________ Age __________

Dental History

	Yes	No
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? __________

	Yes	No
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: __________