Highlands Ranch Orthodontics, P.C.
For Children and Adults

303.791.2021
bracesbydarrell@gmail.com

Excellence in orthodontic care

ADULT PATIENT HISTORY INFORMATION FORM

Patient's Name_____Nickname_____Sex: M____ F____

Home Address_____ City_____ Zip_____

Employer_____Work # _____ Email:_____DOB ___ ___ ___

Home Phone _____Patient's Physician and Phone_____

Who will be financially responsible for the account? _____

Phone and Address of responsible party? _____

Orthodontic Insurance? _____**YES** _____ **NO** _____

Patients' Marital Status: Married_____**Separated**_____**Divorced**_____**Widowed**_____

PATIENT MEDICAL HISTORY

Is the patient experiencing any health problems? Yes____ No____Reason_____

Any major or unusual illnesses? Yes____ No____Explain _____

Currently under physicians care? Yes____ No____Reason_____

Currently taking medication? Yes____ No____List _____

Allergies? Yes____ No____List _____

Drug sensitivity or Drug Allergies? Yes____ No____List _____

Has the patient ever received blood transfusion? Yes____ No____Reason_____

Please Check if Patient has or had any of the Following:

____ Heart Murmur

____ Anemia

____ Blood Disease

____ Prolonged Bleeding

____ Diabetes

____ Hepatitis

____ Rheumatic Fever

____ Herpes

____ AIDS or AIDS Related Complex

____ Are you pregnant or is there a possibility that you could be pregnant?

____ Has the patient ever been advised to take antibiotics prior to dental appointments (i.e.for heart problem)?

____ Heart Disease

____ Tuberculosis

____ Endocrine (Hormone)

____ Jaundice

____ Bone Disorders

____ Asthma

____ Epilepsy (or Seizure disorder)

____ Frequent Colds or Flu

____ Mouthbreathing: While awake?

____ Problems While asleep?

____ Tonsillitis

____ Tonsils Removed? Age:____

____ Adenoid infections or Sinus infections

____ Adenoids Removed? Age:____

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PATIENT MOTIVATION FOR TREATMENT

PATIENT NAME: _____

Patients often request changes of their bites, facial appearance changes or relief from pain or discomfort. Please help us understand your concerns by checking the following information; please be specific (**circle the appropriate words** *forward, backward, longer, shorter,* etc.):

1. The Teeth

If teeth could be changed, how would you like them to change?

[ ] straighten the front teeth
[ ] straighten the back teeth
[ ] make the upper teeth [ ] *upper/lower* [ ]
[ ] move upper teeth [ ] *upper/lower* [ ]
[ ] move lower teeth [ ] *longer/shorter* [ ]
[ ] make the line of the upper front teeth more level [ ] *forward/backward* [ ]
[ ] *close* spaces between teeth or *make* spaces for teeth [ ] *forward/backward* [ ]
[ ] other:

2. The Face

If facial appearance could be changed, what would you like to see changed?

[ ] move chin [ ] *forward/backward* [ ]
[ ] move chin [ ] *left/right* to center it [ ]
[ ] move lower lip [ ] *forward/backward* [ ]
[ ] move upper lip [ ] *forward/backward* [ ]
[ ] get rid of sag under lower jaw
[ ] move the area around the nose [ ] *forward/backward* [ ]
[ ] make the profile of the nose [ ] *longer/shorter* [ ]
[ ] move the area under the eyes [ ] *forward/backward* [ ]
[ ] make the cheekbones [ ] *larger/smaller* [ ]
[ ] show [ ] *more/less* [ ] of my [ ] *teeth/gums* [ ] when I smile
[ ] make the lips [ ] *closer together/further apart* [ ] when the teeth are touching
[ ] reduce the strain in the [ ] *chin/lips* [ ] when the lips are touching
[ ] make the face more [ ] *wide/narrow* [ ]
[ ] reduce the [ ] *width/fullness* [ ] of the lower jaw behind the mouth
[ ] make teeth centered more to make my face [ ] *upper/lower* [ ]
[ ] other:

3. Symptoms

If you want to reduce pain or discomfort where would it be located? Please be specific about the location; circle the right side, left side or both if they apply.

[ ] in front of the ears [ ] *right / left* [ ]
[ ] below the ears [ ] *right / left* [ ]
[ ] above the ears [ ] *right / left* [ ]
[ ] in the ears [ ] *right / left* [ ]
[ ] neck [ ] *right / left* [ ]
[ ] shoulders [ ] *right / left* [ ]
[ ] teeth [ ] *right / left* [ ]
[ ] sinuses
[ ] eyes [ ] *right / left* [ ]
[ ] jaw click [ ] *right / left* [ ]
[ ] jaw pop [ ] *right / left* [ ]
[ ] jaw locking [ ] *right / left* [ ]
[ ] other: [ ] *right /left* [ ]

Signature: _____ Date: _____

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PATIENT DENTAL HISTORY

Name of local dentist patient sees for cavity checkups /restorative dentistry? _____
Has the patient had any severe jaw or face injuries?_____ Explain:_____
Has the patient had any injuries to any teeth?_____Explain: _____
Has the patient had a history of thumb sucking or finger sucking?_____Stopped?_____
Has the patient consulted with an orthodontist previously? _____
Are you satisfied with the prior treatment? _____

Has There Ever Been A History Of:

____ Clenching Teeth ____ Muscular soreness around head and neck ____Jaw Joint Soreness ____Jaw Joint Popping
_____ Grinding Teeth ____ Headaches (more than normal) _____Jaw Joint Clicking _____Ringing in the Ears
Is there any other information that may be helpful?_____
Why are you seeking an orthodontic consultation? (What problems require correction?)_____

Question or Concerns

_____
_____
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