ALL Care DENTAL

Orthodontic intake form

FOR BRACES AND CLEAR ALIGNERS

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Bring this with the new patient form if this is your first visit here. A parent or guardian fills it in for a patient under 18.

OFFICE USE · CHART NO.	ASSESSMENT DATE

ABOUT THE PATIENT

LAST NAME	GIVEN NAMES	DATE OF BIRTH	AGE	TODAY'S DATE

APT.	STREET ADDRESS	CITY	POSTAL CODE

CELL PHONE	EMAIL	SCHOOL OR OCCUPATION	WHOM MAY WE THANK FOR REFERRING YOU?

YOUR DENTIST	DATE OF YOUR LAST DENTAL VISIT	FAMILY PHYSICIAN	PHONE

PERSON RESPONSIBLE FOR THE ACCOUNT

○ Self ○ Parent or guardian ○ Other: _____

PARENT OR GUARDIAN · for a patient under 18

NAME	RELATIONSHIP TO THE PATIENT	CELL PHONE	EMAIL
SECOND PARENT OR GUARDIAN	RELATIONSHIP TO THE PATIENT	CELL PHONE	EMAIL

ORTHODONTIC INSURANCE

ORTHODONTIC COVERAGE?	INSURANCE COMPANY	PLAN HOLDER	GROUP POLICY NUMBER	CERTIFICATE OR ID NUMBER
○ Yes ○ No				

WHAT YOU WOULD LIKE CHANGED

	YES	NO
1. In your own words, what would you like changed about your teeth or your smile?		
2. Which of these have you noticed?		
☐ Crowded teeth ☐ Gaps between teeth ☐ Front teeth stick out		
☐ Lower jaw sits forward ☐ Teeth do not meet when biting ☐ An upper tooth bites inside a lower one		
☐ Teeth wearing down ☐ Difficulty chewing ☐ Speech affected		
☐ Lips do not close comfortably		
3. Has a dentist told you about a problem with your bite or your jaw?	○	○
If yes, who told you, and what did they say?		
4. Have you seen an orthodontist before? Who, and when?	○	○
5. Have you had a consultation about braces or aligners somewhere else? Where?	○	○
6. Have you ever worn any of these?		
☐ Braces ☐ Clear aligners ☐ A plate ☐ An expander ☐ A retainer ☐ A space maintainer		
If yes, when, and for how long?		
7. How soon would you like to start? ○ As soon as possible ○ Within six months ○ Still finding out		
8. Anything else about your smile or your bite we should know?		

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Patient name _____

TEETH, JAW AND HABITS

		YES	NO
9.	Are you missing any adult teeth, or have you been told you have extra ones? Which? _____	○	○
10.	Have any adult teeth been taken out? Which, and when? _____	○	○
11.	Are any baby teeth still in place? Which? _____	○	○
12.	Have orthodontic X-rays been taken anywhere in the last year? Where? _____	○	○
13.	Does your jaw click, pop or grate?	○	○
14.	Has your jaw ever locked open or shut?	○	○
15.	Do you get headaches, earaches or soreness around the jaw, face or neck? How often? _____	○	○
16.	Do you grind or clench your teeth? ○ Asleep ○ Awake ○ Not sure	○	○
17.	Do you wear a night guard or a retainer now?	○	○
18.	Do you, or did you, suck a thumb, fingers or a soother? Until what age? _____	○	○
19.	Do you breathe through your mouth, snore, or stop breathing in your sleep?	○	○
20.	Have your tonsils or adenoids been taken out? At what age? _____	○	○
21.	Do you have a speech difficulty, or have you seen a speech therapist?	○	○
22.	Have you ever injured your face, mouth, teeth or jaw? What happened? _____	○	○
23.	Do your gums bleed when you brush?	○	○
24.	Do you play a wind instrument or a contact sport? Which? _____	○	○
25.	Do you bite your nails, chew pens, or hold things between your teeth?	○	○
26.	Does anyone in the family have an unusual bite, or crowded teeth? Who? _____	○	○
27.	For a patient under 18, the growth spurt has: ○ Not started ○ Started ○ Finished ○ Not sure		

HEALTH ITEMS THAT MATTER FOR ORTHODONTIC TREATMENT · the new patient form asks the rest

		YES	NO
28.	Are you under the care of a physician at present? For what? _____	○	○
29.	Are you taking any medicines at present? Which? _____	○	○
30.	Any allergies, including latex and metals such as nickel? To what? _____	○	○
31.	Have you ever had a problem with a local anesthetic (freezing)?	○	○
32.	Are you pregnant? If yes, when is your baby due? _____	○	○

33. Have you had, or do you have, any of the following?

☐ Asthma	☐ Bleeding disorder	☐ Bone condition	☐ Cleft lip or palate
☐ Diabetes	☐ Epilepsy or seizures	☐ Heart condition	☐ Hepatitis
☐ Kidney disease	☐ Rheumatic fever	☐ Thyroid problem	☐ Treatment for cancer

Anything ticked above, or anything not listed: _____

SIGNATURE

I certify that the information on this form is true to the best of my knowledge, and I will tell the office if anything changes. This form is for the orthodontic assessment; it is not consent to treatment.

DATE _____ SIGNATURE OF PATIENT, OR PARENT OR GUARDIAN _____

NAME OF PARENT OR GUARDIAN (IF SIGNING FOR A PATIENT UNDER 18) _____ RELATIONSHIP TO THE PATIENT _____

This form holds personal health information. All Care Dental keeps it confidential and uses it to care for you and, when you ask us to, to send claims to your insurer. Please hand it in at the office rather than emailing it.