Dear Parent,

It is with great pride and pleasure that I welcome you and your child to my practice. My staff and I are looking forward to meeting both parents, if possible. At that time we will be answering many of your questions about your child's teeth.

I will examine your child and summarize the answers to the following questions.

1. Is there an orthodontic problem?
2. Can it be corrected?
3. When should it be corrected?
4. How long will it take to correct it?
5. How much will you have to invest to correct it?

Obviously, on the basis of a chairside examination, only highlights can be assessed. There is no charge for this examination appointment.

Depending on the answers to the above questions, I will advise one of the following procedures:

1. Wait! It is too early to make an improvement by doing anything now. You will be seen in 6-12 months for another observation visit.

or 2. No treatment is indicated.

or 3. Full records. Treatment is needed now! Therefore, a complete diagnosis is necessary, utilizing an x-ray of the jaw bone, face and teeth, and plaster models of the teeth. The x-rays and eight photos will be taken here at the office, at your convenience.

Your entire financial investment in orthodontic treatment will be presented and all of your questions concerning treatment will be answered.

Please print the dental health history form and fill it out and bring it to your appointment. If my staff or I can be of any assistance we invite you to call us.

Again, we look forward to meeting you and your child

Sincerely,

Todd Aki, D.D.S., M.S.

ACQUAINTANCE & HEALTH HISTORY

Date:

PERSONAL INFORMATION

Patient's Name_____Nickname_____ Sex_____
Mailing Address_____ Date of Birth _____Age_____
Street city state zip
Home Phone_____ Name of Family Physician_____
Dentist _____Patient's Social Security # _____
Whom may we thank for this referral. _____ Hobbies/Interest _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient	_____	_____
Name	_____	_____
Address & Phone Number	_____	_____
How Long at This Address	_____	_____
Employers Name	_____	_____
Business Phone	_____	_____
Occupation	_____	_____
Number of Years Employed	_____	_____
Social Security Number	_____	_____
Birth date	_____	_____
Orthodontic Insurance co	_____	_____
Coverage (office use only)	_____	_____

Martial Status ☐ married ☐single ☐divorced ☐widowed

I understand that where appropriate, credit bureau reports may be obtained.
Signature (parent's signature if minor) _____

MEDICAL HISTORY

Is the patient in good health?	☐Yes	☐No	Reason_____
Any major or unusual illnesses?	☐Yes	☐No	Explain_____
Currently under physician's care?	☐Yes	☐No	Reason_____
Currently taking medication?	☐Yes	☐No	List_____
Allergies	☐Yes	☐No	List_____
Drug sensitivity	☐Yes	☐No	List_____

Please check if patient has or had any of the following.

☐Anemia	☐Heart Disease or Murmur	☐ Frequent colds or flu
☐Blood Disease	☐Tuberculosis	☐Tonsilitis
☐Prolonged Bleeding	☐Diabetes	☐ Mononucleosis
☐Hepatitis	☐Endocrine problems	☐Tonsils removed age_____
☐AIDS or HIV positive	☐Bone Disorders	☐Adenoids removed age_____
☐Jaundice	☐Epilepsy	☐Asthma
☐Rheumatic Fever	☐Herpes or Venereal Disease	☐Mouth breathing
☐Malignancies, Tumors or Cancer	☐Emotional Stress	

Growth information for patients under 16 years of age.
Father's Height _____ Mother's Height _____ Adopted ☐Yes ☐No
Girls : Has she started menstruation? ☐Yes ☐No When? _____
Boys: Has his voice changed? ☐Yes ☐No When? _____
Names and ages of patient's brothers and sisters. _____
Have any had orthodontic treatment? ☐Yes ☐No When? _____

DENTAL HISTORY

YES NO

☐ ☐ Has the patient had any severe head or face injuries? Explain:_____
☐ ☐ Has the patient had a history of thumb sucking or finger sucking? Stopped?_____
☐ ☐ Does the patient play any musical instruments? What?_____
☐ ☐ Has the patient consulted an orthodontist previously? _____
☐ ☐ Has the patient had any previous orthodontic treatment? Explain: _____

PLEASE CHECK IF THERE IS A HISTORY OF:

☐clenching teeth ☐headaches ☐jaw joint popping
☐grinding teeth ☐jaw joint soreness ☐ringing in the ears
☐snoring loudly ☐mouth breather ☐tongue thrust
☐high decay rate ☐hard blow to chin ☐speech problems or speech therapy
☐muscular soreness around the head and neck

When was the patient's last visit with their dentist? _____
When was the patient's last dental cleaning? _____
What do you consider to be your main interest in orthodontics? _____
Has your dentist pointed to some orthodontic problem? _____
Does the patient object to braces or any part of orthodontic treatment? _____
Is there any other information which might be helpful? _____

THANK YOU Signed:_____ Date:_____

PRELIMINARY EXAM (FOR OFFICE USE ONLY)

TMJ
Max opening _____ PERIO _____ CROSSBITE_____
Max left lateral _____
Max right lateral _____ CROWDING _____ SPACING _____

LIPS _____ FRENUM _____ TONGUE _____
HABITS _____ CARIES _____ ROTATIONS _____
HYGIENE _____ MIDLINE MAX _____ TEETH
MAND_____PRESENT _____|_____
CLASS ____ DIV___ OVERBITE _____ OVERJET _____
FACIAL PROFILE_____

OBSERVATIONS AND RECOMMENDATIONS