DELTA ORTHODONTIC GROUP

DUNCAN W. HIGGINS, DDS, MSD, FRCD(C)
CERTIFIED SPECIALIST IN ORTHODONTICS

WELCOME TO DELTA ORTHODONTIC GROUP - PLEASE COMPLETE THIS FORM WHERE APPLICABLE

INFORMATION FOR ADULT PATIENTS

Patients Name: _____

Home Address: _____
Address City Postal Code

Birth Date: _____ Present Age: _____ Gender: M ❑ F ❑
Month/Day/Year Year /Months

Home Tel. No: ( ) _____ Patient's Cell: ( ) _____ E-mail: _____

Do you have any children or relatives who have had treatment in this practice? Yes ❑ No ❑

_____

Employer's Name: _____

Name of Spouse: _____ Occupation: _____

Do you have dental insurance which covers orthodontic treatment? Yes ❑ Plan(s) Name: _____ No ❑

Physician: _____ Dentist: _____ Referred by: _____

Are you in perfect health? Yes ❑ No ❑ (If no, give reason) _____

_____

Are you under the care of a physician for any reason? Yes ❑ No ❑
(If yes, give reason) _____

Are you currently taking any medication? Yes ❑ No ❑
(If yes, please list) _____

Do you have a history of:

Diabetes	Yes ❑	No ❑	Epilepsy	Yes ❑	No ❑
Heart Trouble	Yes ❑	No ❑	Gland or Endocrine Problems	Yes ❑	No ❑
Rheumatic Fever	Yes ❑	No ❑	Fainting or Dizziness	Yes ❑	No ❑
Bone Disorders	Yes ❑	No ❑	Nervous Disorders	Yes ❑	No ❑
Congenital Abnormalities	Yes ❑	No ❑	Emotional Disorders	Yes ❑	No ❑
Tuberculosis	Yes ❑	No ❑	Liver Problems	Yes ❑	No ❑
Blood Disorders	Yes ❑	No ❑	Hepatitis	Yes ❑	No ❑
Anemia	Yes ❑	No ❑	HIV Infection	Yes ❑	No ❑
Prolonged Bleeding	Yes ❑	No ❑	Kidney Problems	Yes ❑	No ❑
Frequent Colds	Yes ❑	No ❑	Asthma	Yes ❑	No ❑
Ear Infections	Yes ❑	No ❑	Chronic Nasal Obstruction	Yes ❑	No ❑
Frequent Sore Throat	Yes ❑	No ❑	Mouthbreathing	Yes ❑	No ❑
Adenoid Problems	Yes ❑	No ❑	Have Adenoids been removed?	Yes ❑	No ❑
Tonsillitis	Yes ❑	No ❑	Have Tonsils been removed?	Yes ❑	No ❑

PLEASE COMPLETE PAGE 2 - OVER

Allergies Yes ❑ No ❑

(If yes, please specify) _____

Do you have a history of any other serious illness? Yes ❑ No ❑

(If yes, please specify) _____

Have you had injuries to the head? Yes ❑ No ❑

(If yes, please specify) _____

Have you been informed of any missing or extra teeth? Yes ❑ No ❑

Have any teeth been extracted? Yes ❑ No ❑

Have you previously consulted an Orthodontist? Yes ❑ No ❑

Have you had any orthodontic treatment? Yes ❑ No ❑

Do you have a history of:

Thumbsucking Yes ❑ No ❑ Until what age _____

Finger sucking Yes ❑ No ❑ Until what age _____

Lip biting or sucking Yes ❑ No ❑ Until what age _____

Tongue thrusting Yes ❑ No ❑

Tooth grinding or clenching Yes ❑ No ❑

Headaches (frequent) Yes ❑ No ❑

Muscular soreness around head and neck Yes ❑ No ❑

Jaw joint soreness Yes ❑ No ❑

Jaw joint clicking of popping Yes ❑ No ❑

Have you received treatment for any of the above problems? Yes ❑ No ❑

(If yes, please specify) _____

_____

Do you have regular dental checkups? Yes ❑ No ❑

Date of last checkup: _____

Toothbrushing: After every meal? ❑ Once per day? ❑ Twice per day? ❑

Do you floss? Yes ❑ No ❑

Reason for seeking orthodontic consultation: _____

_____

_____

Signed: _____ Date: _____

MEDICAL HISTORY UPDATE:

_____

Signed: _____ Date: _____

_____

Signed: _____ Date: _____