PATIENT INFORMATION

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		Relationship
n may we	thank for	referring you to our office?
		DENTAL HISTORY
What	concerns	you most about your teeth?
Yes	No	Is patient presently in any dental pain?
Yes	No	Has patient ever experienced any unfavorable reaction to dentistry?
Yes	No	Has patient ever lost or chipped any teeth?Have there been any injuries to face, mouth, or teeth?
Yes	No	Have there been any injuries to face, mouth, or teeth?
Yes	No	Is any part of patient's mouth sensitive to temperature? Where?
Yes	No	Is any part of patient's mouth sensitive to pressure? Where?
Yes	No	Do patient's gums bleed when brushed?
Yes	No	Does patient have any type of thumb or tongue habit?
Yes	No	Is patient a mouth breather?Has patient ever seen an orthodontist? If yes, who and when?
Yes	No No	What is patient's attitude toward receiving orthodontic treatment?
Yes	No No	Has anyone in your family received orthodontic treatment?
Yes	No	Has anyone in your family received orthodontic treatment? How did they feel about the result?
Yes	No	Do patient's teeth or jaws ever feel uncomfortable upon waking in the morning?
Yes	No	Is patient aware of jaw clicking or popping?
Yes	No	Is patient aware of clenching teeth during the day?
Yes	No	Is patient aware of clenching teeth during the day?Has patient ever been told that he/she grinds their teeth?
Yes	No	Does patient have "tension" headaches?
Yes	No	Has patient ever experienced chronic ringing in the ears?
		Has patient ever experienced chronic ringing in the ears?
Yes	No	Female Patients only: Is there a possibility that patient is pregnant?
Yes	No	Are you aware that some appointments will be during school/work hours?
		Please list some of patient's hobbies or interests
		
		<u>BENEFITS</u>
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