ORTHODONTIC EXAMINATION RECORD

Weintraub & Eltink Orthodontics - 600 N. Buffalo Grove Rd. Suite 200 Buffalo Grove, IL 60089 847-537-0210

Patient's Full Name:_____ Age:___ Date of Birth:_____ M/F Today's Date:_____
Preferred Name:_____ Referred By:_____
Cell Phone:_____ Home Phone:_____
Home Address:_____ City_____ State_____ Zip Code_____
Patient's Dentist:_____
Dental Insurance Company Name:_____ Policy Holder Name:_____
Policy Holder's Member ID/Subscriber ID Number or Social Security Number: _____
Billing Party (Who is financially responsible):_____
Text Reminder: **Y or N** Cell Number for reminders_____
Email Reminder: **Y or N** Email for reminders_____

For Patients under 18 yrs.

Mother or Guardian 1:_____ Father or Guardian 2:_____
Phone Number:_____ Phone Number:_____
Date of Birth:_____ Date of Birth:_____
Email Address:_____ Email Address:_____
Marital Status: Married Divorced Single Widowed

MEDICAL HISTORY

1. Is the patient in good health? . . . . . Yes No
2. Does the patient have any history of major illness? . . . . . Yes No
   If yes, please explain. _____
3. Circle any of the following medical conditions that exist or have existed for the patient:

Diabetes	Birth Defects	Heart Disorders	Bone Disorders	Tonsil/Adenoid Condition
Pneumonia	Tuberculosis	Endocrine Disorders	Kidney Disorders	Mental Health Condition
Cancer	Anemia	Bleeding Disorders	Neurological Disorders	History of Eating Disorder
Rheumatic Fever	Epilepsy	Liver Disorders	Hepatitis B or HIV	High/Low Blood Pressure
Arthritis	Asthma	Fainting/Dizziness	Immune Disorders	Other_____

4. Does the patient require antibiotic pre-medication prior to dental procedures? . . . . . Yes No
5. Does the patient have frequent colds, sore throats, or ear infections? . . . . . Yes No
6. Does the patient chew or smoke tobacco? . . . . . Yes No
7. List any allergies or drug sensitivities:_____
8. List any medications currently being taken:_____
9. Is there any reason X-rays should not be taken? . . . . . Yes No

DENTAL HISTORY

1. Has there been any injury to the face, mouth, or teeth? . . . . . Yes No
2. Has the patient ever sucked their thumb or fingers? . . . . . Yes . . . No . . . . . If yes, until what age?_____
3. Has the patient ever had oral habits such as lip biting or tongue thrusting? . . . . . Yes No
4. Is the patient a mouth breather? . . . . . Yes No
5. Does the patient have any speech problems? . . . . . Yes No
6. Has the patient had any clicking or discomfort in the jaws? . . . . . Yes No
7. Does the patient clench or grind his/her teeth? . . . . . Yes No
8. Has an orthodontist been consulted previously? . . . . . Yes No
9. Is there a family history of jaw size imbalance (under bite or horizontal over bite)? . . . . . Yes No
10. The patient's last dental visit was: _____. Was a Panoramic X-Ray taken? . . . . . Yes No

PATIENT PROFILE (If Patient is Under 18)

1. Does the patient follow directions well? . . . . . Yes No
2. Does the patient brush his/her teeth conscientiously? . . . . . Yes No
3. Does the patient have learning disabilities or need extra help with instructions? . . . . . Yes No
4. Is the patient sensitive or self-conscious about their teeth? . . . . . Yes No
5. Has the patient reached puberty? . . . . . Yes No
6. Has either parent or other children had orthodontic treatment? . . . . . Yes No

Signature _____ **Relationship to Patient** _____ **Date** _____