Patient Name: _____

What are the main concerns that you would like orthodontics to accomplish? Please check;

___My dentist found the problem; dentist name _____
___Better Function/Bite
___Crowding
___Overbite
___Don't like my smile
___Appearance
___Other_____

___Speech Problems
___Missing Permanent Teeth
___Extra Permanent Teeth
___Jaw or Joint Problems

Have you ever been evaluated for or had orthodontic treatment? Yes No if Yes, please explain:
_____

Do you have any of the following habits? Please check;

___Lip Sucking/Biting
___Nail Biting
___Clenching/Grinding Teeth
__ Snoring/Sleep Apnea

___Mouth Breathing
___Tongue Thrusting
___Thumb/Finger Sucking

Patient's attitude towards orthodontic treatment *(children only)*

- Are dental problems causing self-esteem or social issues? Yes No
- Patient's interest in having orthodontic treatment:
  □ Excited □ Willing, if necessary □ Reluctant
- How would you describe your child?
  □ Calm □ Nervous □ Quiet □ Afraid □ Uncooperative □ Cooperative

Growth Information *(for children only)*

Females: Has the patient started her menstruation and/or puberty? Yes No If Yes, at what age? ____
Males: Has the patient undergone voice changes/facial hair growth, and/or puberty? Yes No If Yes, at what age? ____

Whom may we have the pleasure in thanking for referring you? _____

Benefits of Orthodontics: Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Matthew Miner DDS to perform a complete orthodontic evaluation.

Patient/Parent signature: _____ Date: _____