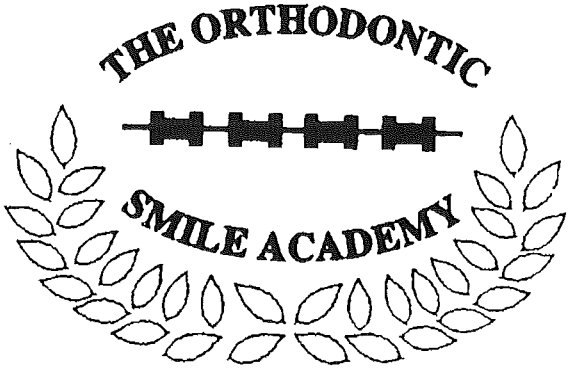
WELCOME TO OUR OFFICE!



GERALD T. LOYACONA, D.M.D.

SPECIALIST IN ORTHODONTICS

www.orthodonticsmileacademy.com

We're glad that you've come to see us and sincerely hope that you enjoy your visit here.

In order to help you we need to know some things about you. Please take your time and fill out this questionnaire completely. If you would prefer to have one of the staff help you in answering the questions, please ask any of us.

Orthodontic treatment is a team effort. The orthodontist and his staff suggest an orthodontic game plan, put in place the necessary equipment to play the orthodontic game, and coach the players. But frequently the orthodontist and staff can't participate as much as they would like in playing, or even directing the course of the game. The patient and family are the most important members of the orthodontic team!

Who will be responsible on your team for your cooperation in wearing appliances (various kinds of braces and retainers? And for proper cleaning (brushing and flossing) of your teeth and gums?

Mother____ Father_____ Self_____

PATIENT INFORMATION

DATE _____

NAME _____ ❒ MALE ❒ FEMALE
LAST FIRST M NICKNAME

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTH DATE_____ AGE_____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL

PLACE OF EMPLOYMENT_____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME_____GRADE _____

PRIMARY DENTIST_____

Names and ages of siblings _____

_____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FATHER (OR HUSBAND) D.O.B._____

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

EMPLOYER

DENTAL INSURANCE SOCIAL SECURITY # GROUP #

MOTHER (OR WIFE) D.O.B._____

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

EMPLOYER

DENTAL INSURANCE SOCIAL SECURITY # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/Zip _____

Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

❒ Patient ❒ Father (or Husband)

❒ Guardian ❒ Mother (or Wife)

❒ _____

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No

Do you have dental examinations on a routine basis? Last visit _____ Yes No

Do you think you have an active decay or gum disease? Yes No

Do you brush and floss on a routine basis? Discuss _____ Yes No

Do your gums ever bleed? Discuss _____ Yes No

Do you like your smile? Why? _____ Yes No

Does food catch between your teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind? _____ Yes No

Any past injury to teeth? Discuss _____ Yes No

Any previous orthodontic treatment? _____ Yes No

Speech therapy, tongue thrust therapy, or myofunctional therapy? Yes No

Please Circle

Any tooth sensitivity? _____ Yes No

Frequent Mouth Ulcers? _____ Yes No

Any previous extractions? _____ Yes No

Recent X-rays? _____ Yes No

Has any near relative ever had facial or jaw surgery? Yes No

Has any near relative ever had a noticeable receding or protruding lower jaw? _____ Yes No

Has anyone in the family had orthodontic treatment? Yes No

Do you suck your finger or thumb? If yes, circle night or day Yes No

Did you ever suck your finger or thumb? _____ Yes No

Do you bite or suck on the inside of your cheek? _____ Yes No

Do you grind your teeth? If yes, circle night and/or day _____ Yes No

Do you clench your jaws? _____ Yes No

Have you ever had periodontal (gums) treatment? _____ Yes No

Have you ever had a root canal? _____ Yes No

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or face? Discuss _____ Yes No

Are you taking any medications, pills or drugs? Specify _____ Yes No

Are you allergic to any medications or substances? Please check box

❒ Aspirin ❒ Penicillin ❒ Acrylic ❒ Metal ❒ Latex Rubber ❒ Other _____ Yes No

Women (Please check): ❒ Pregnant/trying to get pregnant ❒ Nursing ❒ Taking oral contraceptives Discuss _____ Yes No

Pain around ears? _____ Yes No

Frequent headaches _____ Yes No

Tonsils/Adenoids removed _____ Yes No

Premedication required _____ Yes No

Do you now have or have you ever had any of the following? Please check boxes below.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	❒	❒	Hemophilia (Bleeding Problem)	❒	❒	Frequent Diarrhea	❒	❒	HIV Positive	❒	❒
Heart Murmur	❒	❒	Leukemia	❒	❒	Diabetes	❒	❒	Genital Herpes	❒	❒
Irregular Heart Beat	❒	❒	Recent Blood Transfusion	❒	❒	Excessive Thirst	❒	❒	Drug Addiction/Alcoholism	❒	❒
Angina/Chest Pain	❒	❒	Swelling of Limbs	❒	❒	Hypoglycemia	❒	❒	Tattoos	❒	❒
Heart Attack/Failure	❒	❒	Lung Disease	❒	❒	Liver Disease	❒	❒	Cold Sores	❒	❒
Congenital Heart Disorder	❒	❒	Breathing Problem	❒	❒	Hepatitis A (Infectious)	❒	❒	Fever Blisters	❒	❒
Mitral Valve Prolapse	❒	❒	Shortness of Breath	❒	❒	Hepatitis B or C	❒	❒	Herpes	❒	❒
Scarlet Fever	❒	❒	Frequent Cough	❒	❒	Night Sweats	❒	❒	Stroke	❒	❒
Rheumatic Fever	❒	❒	Hay Fever	❒	❒	Yellow Jaundice	❒	❒	Convulsions	❒	❒
Artificial Heart Valve	❒	❒	Sinus Trouble	❒	❒	Kidney Problems	❒	❒	Epilepsy or Seizures	❒	❒
Heart Pace Maker	❒	❒	Asthma	❒	❒	Renal Dialysis	❒	❒	Fainting or Dizziness	❒	❒
Heart Surgery	❒	❒	Bloody Sputum	❒	❒	Thyroid Disease	❒	❒	Glaucoma	❒	❒
High Blood Pressure	❒	❒	Emphysema	❒	❒	Parathyroid Disease	❒	❒	Tumors or Growths	❒	❒
Low Blood Pressure	❒	❒	Tuberculosis	❒	❒	Arthritis/Gout	❒	❒	Nervousness	❒	❒
Blood Disease	❒	❒	Cancer	❒	❒	Rheumatism	❒	❒	Psychiatric Care	❒	❒
Unexplained Fever	❒	❒	X-Ray Treatments (Radiation)	❒	❒	Pain in Jaw Joints	❒	❒	Alzheimer's Disease	❒	❒
Bruise Easily	❒	❒	Chemotherapy	❒	❒	Cortisone Medicine	❒	❒	Allergies (Medication)	❒	❒
Anemia	❒	❒	Stomach / Intestinal Disease	❒	❒	Artificial Joint	❒	❒	Allergies (Pollen / Dust)	❒	❒
Excessive Bleeding	❒	❒	Ulcers	❒	❒	Venereal Disease	❒	❒	Hives or Rash	❒	❒
Sickle Cell Disease	❒	❒	Recent Weight Loss	❒	❒	AIDS	❒	❒	Need Premedication	❒	❒

Jaw Joint (TMJ) Problems

Do you have frequent pain in jaws or jaw joints? Yes No

Do you have frequent headaches? Yes No

Has any doctor ever told you that you might have a TMJ problem? Yes No

Are the jaw (or chewing) muscles frequently sore? Yes No

Do you frequently experience ringing in the ears? Yes No

Are you frequently dizzy? Yes No

Do you frequently experiences tightness, spasms or pain in the muscles of shoulders or back? Yes No

If you have had any of the above problems, how long have you had them?

❒ weeks ❒ months ❒ years

Have you had any previous treatment for TMJ problems? Yes No

Please give a brief summary of a. Who has treated you b. For how long

c. What was done and results. _____

What do you hope or expect that we might do for you? _____

Have you ever had any other serious illnesses not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without failure.

Patient Signature (Parent or Guardian) X _____ Date _____

Reviewed by Doctor _____ Date _____ BP _____

History Review and Significant Findings _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENTS SIGNATURE	BP	REVIEWED BY
_____	_____	None ❒	_____	_____	Dr. _____
_____	_____	None ❒	_____	_____	Dr. _____
_____	_____	None ❒	_____	_____	Dr. _____
_____	_____	None ❒	_____	_____	Dr. _____
_____	_____	None ❒	_____	_____	Dr. _____
_____	_____	None ❒	_____	_____	Dr. _____
_____	_____	None ❒	_____	_____	Dr. _____

CLINICAL EXAMINATION

PATIENT'S NAME _____ **DATE:**_____

Dental Class: ❒ I ❒ II division 1 ❒ II division 2 ❒ III

Vertical: ❒ normal ❒ deep bite ❒ anterior open bite ❒ posterior open bite

Maxillary arch length: ❒ normal ❒ deficiency ❒ excess

Mandibular arch length: ❒ normal ❒ deficiency ❒ excess

Crossbite: ❒ anterior ❒ posterior ___ bilateral ___right ___left

Individual teeth: _____

Diastema: ❒ _____

Midline discrepancy: ❒ _____

Overretained: ❒ _____

Impacted: ❒ _____

Congenitally missing: ❒ _____

Missing: ❒ _____

Abnormal roots and/or crown: ❒ _____

Periodontium: ❒ _____

Enamel markings: ❒ _____

Incisal wear ❒ _____

Habits: ❒ _____

Speech: ❒ _____

Oral Cancer Screening ❒ _____

Oral Hygiene: ❒ Good ❒ Fair ❒ Poor

Soft Tissue:

Midface: ❒ Protrusive ❒ WNL ❒ Retrusive

Lower face: ❒ Protrusive ❒ WNL ❒ Retrusive

Labiomental fold: ❒ Deep ❒ WNL ❒ Shallow

Mentalis: ❒ Strong ❒ WNL ❒ Weak

Lip posture: ❒ Incompetence ❒ Bilabial Protrusion

Asymmetry: _____

TMJ: Right Left ROM: Vertical___ Lateral___ R___ L___

	Right Early	Right Late	Left Early	Left Late
Open/Close Click:	___	___	___	___
Crepitus:	___	___	___	___
Disc lock out	___	___	___	___

❒ Symptomatic ❒ Asymptomatic ❒ Possible problems

TREATMENT PLAN

	Option 1	Option 2	Tx
PHI	_____	_____	_____Fee
PHII	_____	_____	_____Fee
Comp	_____	_____	_____Fee
Ceramics	_____	_____	_____Fee