



Parisi Orthodontics

charting the course to exceptional smiles

Adult Dental History

Date: _____

Patient's Full Name: _____

Date of Birth: __/__/__

General Dentist's name: _____ Last Dentist Visit : __/__/__

Please help us to understand your dental condition and experiences by answering the following questions:

- | | | | |
|-----|-----------------------------------|-----|---|
| Y N | Abscessed or extracted teeth? | Y N | Have had any speech problems? |
| Y N | Injured or chipped teeth? | Y N | Have any TMJ discomfort? |
| Y N | Any severe head injuries? | Y N | Breathe predominantly through your mouth? |
| Y N | Sore or bleeding gums? | Y N | Clench or grind your teeth? |
| Y N | Any jaw noise or pain? | Y N | Have missing permanent teeth? |
| Y N | Limited opening of the jaw? | Y N | Have extra permanent teeth? |
| Y N | Numbness or tingling of the face? | Y N | Have any anxiety about dental work? |
| Y N | Previous orthodontic treatment? | Y N | Was the correction completed? |

Have you had an orthodontic evaluation before? Yes / No

If yes, when and why? _____

What treatment was recommended? _____

Who first suggested the need for orthodontic treatment? _____

What are your main concerns that you would like orthodontics to accomplish?

