

Durk V. Irwin, D.M.D.

ORTHODONTIST BRACES FOR CHILDREN & ADULTS



Member American Association of Orthodontists

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SALMON CREEK 1300 NE 134th St. Vancouver, WA 98685

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

Three horizontal lines for writing concerns.

Have you ever been evaluated or had orthodontic treatment before? [] Yes [] No

Have there been any injuries to the face, mouth, teeth or chin? [] Yes [] No

List any musical instruments played: _____

Have adenoids or tonsils been removed? [] Yes [] No

Have you been informed of any missing or extra permanent teeth? [] Yes [] No

Have you ever had any pain/tenderness in your jaw joint? (TMJ/ TMD) [] Yes [] No

Do you brush your teeth daily? [] Yes [] No

Do you floss your teeth daily? [] Yes [] No

Do you bleach your teeth? [] Yes [] No

Are you currently under the care of a physician? [] Yes [] No

Physician: _____

Phone Number: _____ Date of last visit: _____

Please describe you/your child's current physical health: [] Good [] Fair [] Poor

Please list all medications currently being taken: _____

Please list any food/drug allergies: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- Y N Abnormal Bleeding Y N Clenching/ Grinding Teeth
Y N Anemia Y N Congenital Heart Defect
Y N Artificial Bones/ Joints/ Valves Y N Convulsions/ Epilepsy
Y N Asthma/ Arthritis Y N Diabetes
Y N Blood Transfusion Y N Difficulty Breathing
Y N Cancer/ Chemotherapy Y N Drug/ Alcohol Abuse
Y N Emphysema Y N Mitral Valve Prolapse
Y N Epilepsy/ Seizures/ Fainting Y N Mouth Breather
Y N Fever Blisters/ Herpes Y N Nail Biting

- Y N Glaucoma Y N Psychiatric Problems
Y N Handicaps/ Disabilities Y N Radiation Treatment
Y N Hearing Impairment Y N Rheumatic/ Scarlet Fever
Y N Heart Attack/ Stroke Y N Severe/ Frequent Headaches
Y N Heart Murmur Y N Shingles
Y N Heart Surgery/ Pacemaker Y N Sinus Problems
Y N Hemophilia Y N Speech Problems
Y N Hepatitis Y N Thumb/ Finger Sucking
Y N High/ Low Blood Pressure Y N Tongue Thrust
Y N HIV/ AIDS Y N Tuberculosis (TB)
Y N Hospitalized for any reason Y N Ulcers/ Colitis
Y N Kidney/ Liver Problems Y N Venereal Disease
Y N Lip Sucking/ Biting

PLEASE LIST ANY OTHER MEDICAL PROBLEMS THAT YOU HAVE HAD: _____

Two horizontal lines for listing other medical problems.

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____

Phone Number: _____

Address: _____

Horizontal line for address continuation.

I understand that the information that I have given is correct to the best of my knowledge. I authorize the sharing of this information with my medical and/or dental provider(s).

I authorize the dental staff to perform the necessary dental services needed.

I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics.

Signature of Patient/ Signature of Parent or Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient or guardian and patient named healthy. Doctor's Comments: _____ Initials: _____ Date: _____

Four horizontal lines for doctor's comments.