HULSE ORTHODONTICS

American Association of Orthodontists

invisalign

Dental History

Do you currently have a General Dentist? ☐Yes ☐No **Name of Dentist:**_____
Phone: ( )_____ **Date of your last visit to the dentist:** _____

Have you had a previous orthodontic evaluation? ☐Yes ☐No - **If Yes, when:**_____
What is your main concern for today's orthodontic visit?

History of:			Specifics of Problem if Yes	Please explain all Yes answers
Tooth Injury	Yes	No	Chipped/Broken/Lost	
Jaw Injury	Yes	No	At Age:_____	
Oral Disease	Yes	No	Uclers / Sores	
Jaw Joint Pain	Yes	No	Right: Constant/Periodic	
			Left: Constant/Periodic	
Jaw Joint Noises	Yes	No	Right: Click/Pop/Grating	
			Left: Click/Pop/Grating	
Jaw Joint Locking	Yes	No	Right: When Open/Closed	
	Yes	No	Left: When Open/Closed	
Grinding Your Teeth	Yes	No	During Day/When Sleeping	
Clenching Your Teeth	Yes	No	During Day/When Sleeping	
Bleeding Gums	Yes	No	Brushing/Flossing/Eating	
Oral Habits	Yes	No	Thumb Sucking/Finger Sucking/Tongue Thrusting/Nail Biting	
Other Oral Problems	Yes	No		

Have you ever had:			What Kind of treatment?	Doctor Seen:
Periodontal (gums) Treatment	Yes	No		
Orthodontic (braces) Treatment	Yes	No		
Endodontic (root canal) Treatment	Yes	No		
Oral Surgery (jaw) Treatment	Yes	No		
Prosthodontic (crown/bridge) Treatment	Yes	No		

Benefits

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in the general dental health. Teeth, gums and jaws are intricate body parts 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, my name, and photos may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Hulse and staff to perform a complete orthodontic evaluation which includes diagnostic x-rays. I also understand that if the x-rays are sent to another facility and or Doctor, there will be a charge of $65.00 that I will be responsible for.

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time and that I have also received a copy of this office's Notice of Privacy Practices. If there are any future changes in this information, I will inform this practice of these changes.

Patient or Guardian Signature:_____ **Doctor Signature:**_____

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