

# Terramont ORTHODONTICS

Kendra Covington Pratt, DDS, MS, PA  
Orthodontic Specialist for Children, Teens & Adults  
Board Certified, American Board of Orthodontics

Dear Patient,

Welcome to our practice and thank you for selecting us as your orthodontic care team. Rest assured that every effort will be made to provide the highest quality treatment for you.

It is our desire to provide for your orthodontic needs both thoroughly and efficiently. The initial appointment is spent conducting an examination, reviewing a clinical diagnosis, discussing a treatment plan and, when indicated, taking impressions of the teeth.

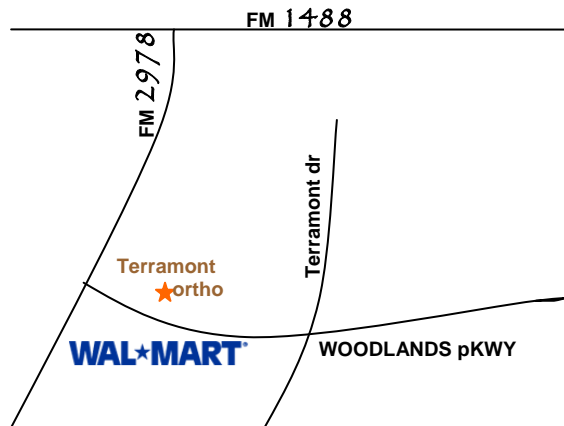
Please refer to the map at the bottom of the page to facilitate locating our office. On our website you may also find new patient and medical history forms. Completing this form prior to your appointment will help decrease the length of your appointment. Please print and bring your new patient questionnaire and medical history along with you to your appointment.

Again, we welcome you to our practice and look forward to seeing you for your orthodontic examination.

Sincerely,

Kendra Covington Pratt, DDS, MS, PA

Terramont Orthodontics  
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The Woodlands, TX 77382  
**281.367.0050**



Member  
American Association of  
Orthodontists



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**invisalign**



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FILE NUMBER:

ORTHODONTIC SCREENING FORM

Patient Information

Name: Nickname: Home Phone:
DOB: Age: Cell Phone:
SSN: Gender:
Email Address: Address:

If Patient Under 18, Please Complete This Section for Responsible Party

Name: Relationship: Cell Phone:
DOB: Marital Status: Work Phone:
SSN: Employer:
Email Address: Address:

Dental Insurance Information

Insurance Company: Phone Number:
Policy Holder's Name: Insured's SSN:
Insured's DOB: Policy Number:
Secondary Insurance:

General Information

School Attended: Siblings & Their Date of Birth(s):
Interests / Hobbies:
Patient's Dentist: Date of Last Visit:
Primary Concern/ Reason for Visit?

How did you hear of our office/ Referral:

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

- Does patient follow directions well?
Does patient brush his/her teeth conscientiously?
Does patient have learning disabilities or need extra help with instructions?
Is patient sensitive or self-conscious about teeth?

- Latex (gloves, balloons)
Vinyl
Acrylic
Animals
Foods (specify)
Other substances (specify)
Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Allergies or reactions to any of the following:

- Local anesthetics (Novocaine or Lidocaine)
Aspirin
Ibuprofen (Motrin, Advil)
Penicillin or other antibiotics
Sulfa drugs
Codeine or other narcotics
Metals (jewelry, clothing snaps)

- Medication Taken for
Medication Taken for
Medication Taken for
Does the patient currently have or ever had a substance abuse problem?
Does the patient chew or smoke tobacco?

## MEDICAL HISTORY

Now or in the past, has the patient had:

- yes no dk/u Birth defects or hereditary problems?  
yes no dk/u Bone fractures, any major accidents?  
yes no dk/u Rheumatoid or arthritic conditions?  
yes no dk/u Endocrine or thyroid problems?  
yes no dk/u Kidney problems?  
yes no dk/u Diabetes?  
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?  
yes no dk/u Stomach ulcer or hyperacidity?  
yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?  
yes no dk/u Problems of the immune system?  
yes no dk/u AIDS or HIV positive?  
yes no dk/u Hepatitis, jaundice or liver problem?  
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?  
yes no dk/u Mental health disturbance or behavioral problem?  
yes no dk/u Vision, hearing, tasting or speech difficulties?  
yes no dk/u Loss of weight recently, poor appetite?  
yes no dk/u History of eating disorder (anorexia, bulimia)?  
yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?  
yes no dk/u High or low blood pressure?  
yes no dk/u Tires easily?  
yes no dk/u Chest pain, shortness of breath or swelling ankles?  
yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?  
yes no dk/u Skin disorder?  
yes no dk/u Does the patient eat a well-balanced diet?  
yes no dk/u Frequent headaches, colds or sore throats?  
yes no dk/u Eye, ear, nose or throat condition?  
yes no dk/u Hay fever, asthma, sinus trouble or hives?  
yes no dk/u Tonsil or adenoid conditions?  
yes no dk/u Operations?  
Describe: \_\_\_\_\_  
yes no dk/u Hospitalized?  
For: \_\_\_\_\_  
yes no dk/u Other physical problems or symptoms?  
Describe: \_\_\_\_\_  
yes no dk/u Being treated by another health care professional?  
For: \_\_\_\_\_  
Date of most recent physical exam? \_\_\_\_\_  
Are there any other medical conditions that we should be aware of? \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

- Bleeding disorders \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Metabolic disturbances \_\_\_\_\_  
Severe allergies \_\_\_\_\_  
Unusual dental problems \_\_\_\_\_  
Jaw size imbalance \_\_\_\_\_  
Any other family medical conditions that we should know about? \_\_\_\_\_

## DENTAL HISTORY

Now or in the past, has the patient had:

- yes no dk/u Primary (baby) teeth removed that were not loose?  
yes no dk/u Supernumerary or "extra" teeth?  
yes no dk/u Congenitally missing teeth?  
yes no dk/u Missing teeth from extractions?  
yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?  
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?  
yes no dk/u Jaw fractures, cysts or mouth infections?  
yes no dk/u "Dead teeth" or root canals treated?  
yes no dk/u Bleeding gums, bad taste or mouth odor?  
yes no dk/u Periodontal "gum problems"?  
yes no dk/u Food impaction between teeth?  
yes no dk/u Thumb, finger, or sucking habit? Until what age? \_\_\_\_\_  
yes no dk/u Abnormal swallowing habit (tongue thrusting)?  
yes no dk/u History of speech problems?  
yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?  
yes no dk/u Tooth grinding, jaw clenching, clicking or locking?  
yes no dk/u Any pain in jaw or ringing in the ears?  
yes no dk/u Any pain or soreness in the muscles of the face or around the ears?  
yes no dk/u Difficulty encountered in chewing or jaw opening?  
yes no dk/u Aware of loose, broken or missing restorations (fillings)?  
yes no dk/u Any teeth irritating cheek, lip, tongue or palate?  
yes no dk/u Aware or concerned about under or over developed jaw?  
yes no dk/u "Gum Boils", frequent canker sores or cold sores?  
yes no dk/u Any relative with similar tooth or jaw relationships? Who \_\_\_\_\_  
yes no dk/u Had periodontal (gum) treatment?  
yes no dk/u Would patient object to wearing metal or clear braces should they be indicated?  
yes no dk/u Any serious trouble associated with any previous dental treatment?  
yes no dk/u Ever had a prior orthodontic examination or treatment?

I authorize Dr. Kendra Pratt to assess \_\_\_\_\_ for the possibility of orthodontic treatment. I understand that this is not a contract to any treatment and a final determination of treatment will be made after the case has been fully diagnosed with appropriate diagnostic records. I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_