

Henry D. Browning IV, D.D.S., P.A. Orthodontics for Children & Adults

604 Junction Creek Drive ♦ Wilmington, NC 28412 ♦ (910) 793-2520

Date _____ 20____

Patient's Name _____ Patient's birthdate _____ Age _____ Gender _____

Patient's Primary Address _____ City _____ State _____ Zip Code _____

Patient Lives With Mother Father Both Parents Other _____ Telephone (____) _____

School _____ Grade _____ Referred by _____

Patient's Dentist _____ Physician _____

Patient's last professional dental cleaning and check-up _____ Siblings/Age _____

Medical History

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Involvement	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Involvement	<input type="checkbox"/>	<input type="checkbox"/>	Fainting & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	HIV (AIDS virus)	<input type="checkbox"/>	<input type="checkbox"/>

Do you require premedication before dental appointments? _____ Yes No

Are you in good health? _____ Yes No

Are you under the care of a physician (if so, why?) _____ Yes No

List any medications you are taking at this time: _____

List any allergies or drug sensitivities: _____

List any other medical conditions: _____

Has patient reached puberty? Girls – have you started menstruation? _____

Boys – has your voice changed? _____

Signature _____ Date _____
(parent or guardian if patient is a minor)



Date _____ M / D Panorex _____ Photos _____

Molars	R _____	L _____	OB _____	OJ _____	Primary dentition:
Cuspids	R _____	L _____			
Midline	Mx _____	Md _____	Crossbite		

Upper crowding _____ Lower crowding _____

Profile _____	Oral hygiene _____	TMJ	R	L
Lip posture _____	Caries _____	Click		
Chin-throat depth _____	Perio _____	Pain		
Labiomental fold _____	Eruption concerns _____	Trauma		
Abnormal frenum _____		Max. opening _____		
Attitude towards treatment _____	Habits _____	CR = C0 _____		
Other: _____				

Recommendation: Obs / Phase I / Phase II / Other _____ Spacers _____ Bands _____

Extractions / Impactions / Surgery _____ Upper _____ Lower _____

Estimated Length of Treatment: _____ Expander _____ Retainers _____