Patient Number:_____ Date: _____

Tingrinners Club Jamaica

The Offices of Dr. med. dent Otto Beck and Dr. Nigel Knight D.D.S.
58 Half Way Tree Road, Kingston 10, Jamaica W.I.
Phone (876) 929-6836-7
FAX (876) 929-6838
E-Mail: info@tingrinner.com
Web-Site: www.SmileTingrinner.com

ADULT ORTHODONTIC CONSULTATION

Name:

Date of Birth:

Address:

Phone (Home): (Cellular):

E-Mail:

Occupation:

Place of Employment:

Business Phone:

Spouse's Name:

Occupation:

Bus. Phone:

General Dentist:

Last Visit:

Physician:

Who referred you to this office?

Who will be responsible for this account?

Address (if other than the above):

Employed by:

Do you have dental insurance that may provide orthodontic benefits?

In your own words, what is the problem?

MEDICAL AND DENTAL HISTORY (This information is confidential and for our use only):

Have you seen an orthodontist previously? ……

Was any treatment provided? …….

How many times do you brush daily? ……..

Do you: Floss? _____How often? _____

Smoke? _____ How many per day? _____

Take any medication regularly? _____ What? _____

Have you ever had: Please explain any “Yes” answers below:

- Tonsils & adenoids removed? .....
- Periodontal therapy?.....
- Rheumatic fever? ……..
- Trauma to the head, face or teeth? .....
- Surgery of the head or face? …..……

Do you have:

- Drug or other allergy, hay fever, asthma? ……..…
- Difficulty breathing through nose (awake and/or asleep)? ……..
- Frequent headaches? ……
- Sinus problems? …….....
- Earaches? ……...
- An unusual amount of stress in your life? …….....
- Any habits such as nail biting, teeth clenching, lip biting? …….
- Any speech problems? …….
- Frequent neck or back aches? ……...
- A low pain tolerance? ……...
- Difficulty opening your mouth wide? ……..
- Clicking, popping or other noises when opening or closing your jaws? ……..…

- Any other health problems? …….
- Any special concern about undergoing orthodontic treatment? ……