MEDICAL HISTORY

Your current health is: Good___Fair___Poor___
Do you have a personal physician? ___Y___N
Physicians Name:_____
Phone #:_____Date of last visit:_____
Are you currently under the care of a physician? ___Y___N
Please explain:_____
Taking any prescription/over-the-counter drugs? ___Y___N
Please list each one:_____
Are you pregnant? ___Y___N

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Diabetes
Y N Difficulty Breathing/Snoring
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures/Fainting
Y N Glaucoma
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery/Pace Maker
Y N Hemophilia
Y N Liver Disease
Y N Lung Disease
Y N Stroke
Y N Allergies/Hives
Y N Hepatitis
Y N HIV/AIDS
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Tuberculosis
Y N Ulcers
Y N Colitis
Y N Venereal Disease
Y N Dialysis
Y N Sinus Problems
Y N Thyroid Disease
Y N Mouth Sores/Growths
Y N High/Low Blood Pressure
Y N Hospitalized for any reason

DENTAL HISTORY

Have you ever been evaulated for orthodontic treatment? ___Y___N

What are your main concerns that an orthodontist could address? _____

_____

Have you ever had a problem associated with previous dental work? ___Y___N
Have you ever experienced jaw joint pain or discomfort? ___Y___N

Your current dental health is: Good___Fair___Poor___
Do your gums ever bleed? ___Y___N
Have you ever had an injury to: Mouth___Teeth___Chin___
Do you have any missing or extra perminant teeth? ___Y___N
Have you ever taken bisphosponate? ___Y___N

Have you ever experienced any of the following:

Y N Clinching/Grinding
Y N Lip Sucking/Biting
Y N Mouth Breathing
Y N Nail Biting
Y N Pacifier
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

Are you allergic to any of the following?

Y N Asprin
Y N Any Metal/Plastics
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline

Other:_____

Sleep Behavior: Do you snore? ___Y___N Do you seem tired during the day?___Y___N
Do you grind your teeth during sleep? ___Y___N

INFORMATION & CONSENT

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventative or basic procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

I consent to taking disgnostic records, including X-Rays, before, during and after treatment. I understand records may be taken by doctor(s) or staff when appropriate, to provide treatment prescribed by the doctor(s) for the below individual. I fully understand all risks associated with treatment.

Signature: Date:

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian of the patient named herein.

Initials:_____ Date:_____

Doctor Comments:_____

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Date:_____

Patients Legal Name:_____ Nickname:_____

Birthdate:____/____/____ Age:_____ Sex: Male/Female Marital Status: S/W/M/D School/Grade:_____

Home Address:_____

Email:_____

Home Phone #: _____ Mobile Phone #:_____ Mobile Carrier:_____

Hobbies/Interests:_____ Siblings/Ages:_____

Emergency Contact Name:_____ Relationship:_____ Phone:_____

RESPONSIBLE PARTY INFORMATION

Name:_____ Birthday: ____/____/____ Relationship:_____

Billing Address:_____ How long at this address: _____

Employer:_____ Cell/Work #:_____Ext:_____ How long?_____

Name:_____ Birthday: ____/____/____ Relationship:_____

Billing Address:_____ How long at this address: _____

Employer:_____ Cell/Work #:_____Ext:_____ How long?_____

GENERAL INFORMATION

General Dentist:_____Last Visit Date:_____

Other Dental Specialists:_____

Whom may we thank for referring you?_____

Does anyone in the family need orthodontics? _____Yes_____No If yes, who?_____

DENTAL INSURANCE

PRIMARY:

Ins. Co. Name:_____ Group #:_____

Ins. Co. Address:_____

Ins. Co. Phone:_____Insured ID #:_____

Insured's Name:_____Relation:_____D.O.B:_____

Insured's Employer:_____

If there is a secondary insurance plan, please see front desk for an additional form so we can gather that additional information.