CURRENT ORTHODONTICS

WELCOME TO OUR OFFICE
MEDICAL DENTAL HISTORY FORM

A B C

Confidential ***RESPONSIBLE PARTY*** Information

Name: _____Marital Status: _____
RESONSIBLE PARTY LAST FIRST MIDDLE

Residence: _____Rent____ Own_____
Street City State Zip

Mailing Address: _____
Street City State Zip

How long at this address _____Home phone _____Work Phone _____

Previous address(if less than 3 yrs) _____
Street City State Zip

Social Security #_____Birthdate_____Relationship to Patient_____

Employer _____Occupation _____No. Years Employed _____

Spouse's Name_____Relationship to Patient_____

Employer _____Occupation _____No. Years Employed _____

Social Security # _____Birthdate _____

EMAIL Address:

Confidential *PATIENT* Information

Patient's Name _____
Last First Middle

Address _____

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

School _____**Whom my we thank for referring you to our office?**

Insurance Information

Policy Holder's Name _____and Soc. Sec. # _____

Insurance Company _____Mem ID. _____Grp No._____

Insurance Co. Address _____ Ins. Phone No. _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Address _____Phone _____
Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's Signature if minor) _____

Now or in the past, have you 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? If yes, Type I or Type II?

☐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 Do you 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 Tonsil or adenoid conditions?

☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble?

☐yes ☐no ☐dk/u Osteoporosis?

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Latex (gloves, balloons)

☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)

☐yes ☐no ☐dk/u Local anesthetics, such as Lidocaine

☐yes ☐no ☐dk/u Acrylic

☐yes ☐no ☐dk/u Medications (please specify)_

_____

☐yes ☐no ☐dk/u Foods (please specify)_____

☐yes ☐no ☐dk/u Other substances (specify)_____

☐yes ☐no ☐dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? If yes, please name them:
Medication_____ Taken for_____
Medication_____ Taken for_____

☐yes ☐no ☐dk/u Do you currently have or ever had a substance abuse problem?

☐yes ☐no ☐dk/u Do you smoke or chew tobacco?

☐yes ☐no ☐dk/u Operations? Describe: _____

☐yes ☐no ☐dk/u Hospitalized? For: _____

☐yes ☐no ☐dk/u Being treated by another health care professional? If yes, for:

_____

☐yes ☐no ☐dk/u Other physical problems or symptoms? Describe:

_____

Now or in the past, have you had:

☐yes ☐no ☐dk/u Permanent or "extra" (supernumerary) teeth removed?

☐yes ☐no ☐dk/u Supernumerary (extra) or congenitally missing teeth?

☐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 "Gum Boils", frequent canker sores or cold sores?

☐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 Have you ever been treated for "TMD" or "TMJ" problems?

☐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 Concerned about spaced, crooked or protruding teeth?

☐yes ☐no ☐dk/u Aware or concerned about under or over developed jaw?

☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?

☐yes ☐no ☐dk/u Any wisdom tooth problems?

☐yes ☐no ☐dk/u Had periodontal (gum) treatment?

☐yes ☐no ☐dk/u Had any serious trouble associated with any previous dental treatment?

☐yes ☐no ☐dk/u Been under another dentist's care?

☐yes ☐no ☐dk/u Been under another dental specialist's care?

☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?

☐yes ☐no ☐dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

WOMEN ONLY

☐yes ☐no ☐dk/u Are you pregnant?

☐yes ☐no ☐dk/u Are you anticipating becoming pregnant?

General Dentist's Name:_____

Are there any other medical conditions (including family medical conditions) should be aware of?

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