

Medical History

Physician _____ Date of last visit _____

Address _____ Phone _____ Fax _____

Please circle Yes or No (if Yes, please fill in details)

YES NO Are you taking any medication? _____

YES NO Are you allergic or had any adverse reactions to any medications? _____

YES NO Do you have a history of major illness? _____

YES NO Have you had any major operations? _____

YES NO Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

AIDS	Diabetes	Hepatitis	Nervous Disorders	Tumor or Cancer
Anemia	Dizziness	Herpes	Pneumonia	
Arthritis	Epilepsy	High Blood Pressure	Prolonged Bleeding	
Asthma or Hay Fever	Kidney Involvement	Rheumatic Fever	Gastrointestinal Disorders	
Bone Disorders	Heart Problems	Liver Involvement	Tuberculosis	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

If child, have you reached puberty? Girls – have you started menstruation? _____ Boys – has your voice changed? _____

Dentist

Dentist _____ Date of last cleaning _____

Address _____ Phone _____ Fax _____

Dental Concerns

Please describe what concerns you most about your teeth _____

Dental History

YES NO Are you presently in any dental pain? _____

YES NO Have you ever experienced any unfavorable reaction to dentistry? _____

YES NO Have you ever lost or chipped any teeth? _____

YES NO Have there ever been any injuries to the face, mouth or teeth? _____

YES NO Is any part of your mouth sensitive to temperature or pressure? _____

YES NO Do your gums bleed when you brush? _____

YES NO Do you have any type of thumb, finger or tongue habit? _____

YES NO Are you a mouth breather? _____

YES NO Have you ever seen an orthodontist? _____

YES NO Has anyone in the family received orthodontic treatment? _____

How did they feel about the result? _____

What is your attitude toward receiving orthodontic treatment? _____

YES NO Do you have any pain or soreness around your face, neck or back? _____

YES NO Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____

YES NO Are you aware of your jaw clicking or popping? _____

YES NO Are you aware of clenching your teeth during the day? _____

YES NO Have you been told you grind your teeth? _____

YES NO Do you have "tension" headaches? _____

YES NO Have you ever experienced ringing in your ears? _____

YES NO Are you aware that some appointments will be during school/work hours? _____

Benefits of Orthodontics – AESTHETICS, HEALTH AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance and general function of the teeth, and in general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases.

I hereby state that I have read and understood the above paragraph and that I have truthfully to the best of my ability answered all the above questions.

Patient/Parent

Date

PATIENT REGISTRATION AND MEDICAL HISTORY
(Please print)

Welcome! Our specialty is creating beautiful smiles and to do this we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.

Date _____ Home Phone _____

Work Phone _____ Cell Phone _____

Patient _____

First Name

Last Name

Preferred Name

Street Address _____ City _____ State _____ Zip _____

Gender: M or F _____ Age _____ Birth Date _____

Responsible Party Information

Who is financially responsible for this account? _____

Relationship to patient _____

Responsible Party social security number _____

Name of Dental Insurance Company _____ Group # _____

Policy Holder name _____

Policy Holder social security number _____

Policy Holder date of birth _____

In case of emergency, who should be notified? _____ Phone _____

Who may we thank for referring you to our office? _____

E-mail address _____

Patient Hobbies _____

Parent/Patient/Guardian Signature _____ Date _____

By signing I agree the above information is correct to the best of my knowledge.

Doctor Signature _____ Date _____

I have reviewed the above information and medical history.