

## Patient Dental History

What are the main concerns that you would like orthodontics to accomplish?

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Has the patient ever been evaluated or had orthodontic treatment before?      Yes      No

Have there ever been any injuries to the face, mouth, teeth or chin?      Yes      No

Has the patient been informed of any missing or extra permanent teeth?      Yes      No

Has the patient ever had any pain/tenderness in the jaw joint?      Yes      No

Name of Dentist \_\_\_\_\_ Phone# \_\_\_\_\_

Does the patient have any speech problems?

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Has the patient ever had a serious/difficult problem associated with any previous dental work?      Yes      No

The patient's current dental health is:    Good      Fair      Poor

## Patient Habits

Does/did the patient have any of the following habits?

Y N Clenching Teeth

Y N Grinding Teeth

Y N Lip Sucking/Biting

Y N Mouth Breather

Y N Thumb/Finger Sucking (circle one)

Y N Past habit or current habit (circle one)

Y N Tongue Thrust

## Patient Medical History

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last visit \_\_\_\_\_

Patient's physical health is:      Good      Fair      Poor

Is the patient under the care of a physician?      Yes      No

Please list all drugs that the patient is taking \_\_\_\_\_

For Women: Are you pregnant?      Yes      No      Week # \_\_\_\_\_

Are you nursing?      Yes      No

Comments: \_\_\_\_\_

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## Authorization and Release

I certify that I have answered the above questionnaire accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my medical and dental health. I authorize the office to release any information including the diagnosis and records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on the patient's behalf. I understand that where appropriate, credit bureau reports may be obtained.

X \_\_\_\_\_  
Signature of patient (or parent if a minor)

\_\_\_\_\_  
Date

Has the patient ever had any of the following diseases or medical problems? Please discuss any of the marked items or any other medical problems that the patient has had in the space below.

Y N Anemia/Radiation Treatment

Y N Any Hospital Stays

Y N Any Operations

Y N Artificial Valves

Y N Arthritis

Y N Asthma

Y N Blood Transfusion

Y N Cancer/Chemotherapy

Y N Congenital Heart Defect

Y N Convulsions/Epilepsy

Y N Diabetes

Y N Drug/Alcohol Abuse

Y N Emphysema/Glaucoma

Y N Fever Blisters/Herpes

Y N Handicaps/Disabilities

Y N Heart Attack/Stroke

Y N Heart Surgery/Pacemaker

Y N Hemophilia/Abnormal Bleeding

Y N Hepatitis

Y N High/Low Blood Pressure

Y N HIV+/AIDS

Y N Kidney/Liver Problems

Y N Mitral Valve Prolapse

Y N Psychiatric Problems

Y N Respiratory Problems

Y N Rheumatic/Scarlet Fever

Y N Severe/Frequent Headaches

Y N Shingles

Y N Sinus Problems

Y N Tuberculosis

Y N Ulcer/Colitis

Y N Venereal Disease

Y N Orthopedic Total Joint

Y N Any Complications w/  
Orthopedic Joint

Is the patient allergic to any of the following?

Y N Aspirin

Y N Any Metal/Plastic

Y N Codeine

Y N Dental Anesthetics

Y N Erythromycin

Y N Any Sulfa Drug

Y N Latex

Y N Penicillin or any related cillin drug

Y N Tetracycline

Y N Iodine

Y N Other

Please list any other drugs that the patient is allergic to:

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Does the patient have any condition(s) requiring pre-medications?

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