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PRACTICE LIMITED TO ORTHODONTICS

PATIENT INFORMATION

Age ________________

Date ___________ Birthdate _____/_____/_____

Name ____ Preferred to be called ________________
(last) (middle) (first)

Address ____
(number) (street) (city) (zip)

Telephone ____
(home) (cell) (business)

Email ________________________________ SS# ________________________________

Employer ____________________________________ Occupation ____________________

Business Address ____
(street) (city) (zip)

Marital Status: Single _______ Married _______ Divorced _______ Remarried _______ Widowed _______

Name of Spouse __________________________ Spouse's occupation ____________________

Spouse's Employer ____

Reason for your visit to our office? ____

Has patient received previous orthodontic consultation? __________ Treatment?____________________

Whom might we thank for your referral? ____

Do you have any other family members in our practice? ________ If so, Whom? ____________________

DENTAL HISTORY

Dentist ____________________________________ Phone ____________________

Address ____
(street) (city) (zip)

Other Dentist ________________________________ Specialty ____________________

Address ____
(street) (city) (zip) (phone)

Date of last dental visit __________________________ Date of last full-mouth X-ray ______________

MEDICAL HISTORY

Family Physician _____________________________ Specialty ____________________

Address ____
(street,city,zip) (telephone)

Additional Physician __________________________ Specialty ____________________

Address ____
(street,city,zip) (telephone)

Date of last complete medical examination ____________________________________

Over

MEDICAL HISTORY

CIRCLE

1. Are you having dental pain or discomfort? ....YES NO
2. Are you currently under physicians care? ....YES NO
   If yes, Explain ____
3. Are you taking any medications? ....YES NO
   If yes, Please List ____
4. Are you allergic to any medications, food, or latex?..YES NO
   If yes, Which ____
5. Do you take medicines prior to dental treatment? ....YES NO
   If yes, Please list ____
6. Have you ever had any excessive bleeding requiring special treatment?..YES NO
   If yes, which ____
7. Have you ever had any trauma?..YES NO
8. Has anyone in your family had orthodontic treatment that has caused root resorption?............................YES NO
9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness or breath, or because you are very tired?..YES NO
10. Do your ankles swell during the day?..YES NO
11. Do you have any disease, condition, or problem not listed?..YES NO
    If yes, Please list ____
12. WOMEN: Are you pregnant now?..YES NO
    Do you anticipate becoming pregnant?..YES NO
13. Do you breath through your mouth?..YES NO
    Do you snore when you are asleep?..YES NO
    Do you sleep with your mouth open?..YES NO
    Do you have sleep apnea?..YES NO
    Do you sleep with a CPAP?..YES NO
14. **Circle** any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	HIV Positive
Angina Pectoris	Tuberculosis (TB)	Hepatitis A (infectious)
High Blood Pressure	Asthma	Hepatitis B (serum)
Heart Murmur	Hay Fever	Liver Disease
Heart Pacemaker	Sinus Trouble	Rheumatic Fever
Heart Surgery	Blood Transfusion	Drug Addiction
Congenital Heart Lesions	Diabetes	Hemophilia
Mitral Valve Prolapse	Thyroid Disease	Cold Sores
Venereal Disease (Syphilis, Gonorrhea)	Artificial Heart Valve	X-ray or Cobalt Treatment
Allergies or Hives	Cancer/Tumor	Chemotherapy
Arthritis	Genital Herpes	Artificial Joint
Rheumatism	Epilepsy or Seizures	Anemia
Cortisone Medicine	Fainting or Dizzy Spells	Stroke
Glaucoma	Nervousness	Kidney Trouble
Pain in Jaw Joints	Psychiatric Treatment	Ulcers
Bruise Easily	Sickle Cell Disease	Scarlet Fever

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or change in medications, I will inform the office and doctor at the next appointment without fail.

____________________ ______________________________________

Date *Signature of Patient, Parent or Guardian*

*Doctor's Initials*________