Patient Medical History

Physician_____ **Office Phone** _____ **Date of Last Exam**_____

	YES	NO
1. Are you under medical treatment now?	O	O
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____ _____	O	O
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	O	O
4. Have you ever taken Phen-Fen/Redux?	O	O
5. Do you use tobacco?	O	O
6. Do you use controlled substances?	O	O

7. Do you have or have you had any of the following:

	YES	NO
High Blood Pressure	O	O
Heart Attack	O	O
Rheumatic Fever	O	O
Swollen Ankles	O	O
Fainting / Seizures	O	O
Asthma	O	O
Low Blood Pressure	O	O
Epilepsy / Convulsions	O	O
Leukemia	O	O
Diabetes	O	O
Kidney Diseases	O	O
AIDS or HIV Infection	O	O
Thyroid Problem	O	O
Heart Disease	O	O
Cardiac Pacemaker	O	O
Heart Murmur	O	O
Angina	O	O
Frequently Tired	O	O
Anemia	O	O
Emphysema	O	O
Cancer	O	O
Arthritis	O	O
Joint Replacement or Implant	O	O
Hepatitis / Jaundice	O	O
Sexually Transmitted Disease	O	O
Stomach Troubles / Ulcers	O	O
Chest Pains	O	O
Easily Winded	O	O
Stroke	O	O
Hay Fever / Allergies	O	O
Tuberculosis	O	O
Radiation Therapy	O	O
Glaucoma	O	O
Recent Weight Loss	O	O
Liver Disease	O	O
Heart Trouble	O	O
Respiratory Problems	O	O
Mitral Valve Prolapse	O	O
Other_____	O	O

8. Are you allergic to or have you had any reactions to the following:

	YES	NO
Local Anesthetics (eg. Novocaine)	O	O
Penicillin or any other Antibiotics	O	O
Sulfa Drugs	O	O
Barbiturates	O	O
Sedatives	O	O
Iodine	O	O
Aspirin	O	O
Any Metals (eg. nickel, mercury, etc.)	O	O
Latex Rubber	O	O
Other_____	O	O

9. Women Only:

Are you pregnant or think you may be pregnant?	O	O
Are you nursing?	O	O
Are you taking oral contraceptives?	O	O

Patient Dental History

General Dentist and Location_____ **Date of Last Exam**_____

	YES	NO
1. Do your gums bleed while brushing or flossing?	O	O
2. Are your teeth sensitive to hot or cold?	O	O
3. Are your teeth sensitive to sweet or sour?	O	O
4. Do you feel pain in any of your teeth?	O	O
5. Do you have any sores or lumps in your mouth?	O	O
6. Have you had any head, neck or jaw injuries?	O	O
7. Have you ever experienced any of the following problems with your jaw?		
Clicking	O	O
Pain (joint, ear, side of face)	O	O
Difficulty opening, closing, or chewing	O	O
8. Do you have frequent headaches?	O	O
9. Do you clench or grind your teeth?	O	O
10. Do you bite your lips or cheeks frequently?	O	O
11. Have you ever had any difficult extractions?	O	O
12. Have you ever had any prolonged bleeding following extractions?	O	O
13. Have you had any orthodontic treatment?	O	O
14. Do you wear dentures or partials? If yes, date of placement _____	O	O
15. Do you like your smile? If no, what do you not like_____ _____	O	O

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the orthodontist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such orthodontic care to third party payors 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 dental insurace carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. _____ _____

Signature of Patient (or parent if minor) Date