

## MEDICAL AND DENTAL HISTORY

Would you consider your health to be:

Excellent ( ) Good ( ) Fair ( ) Poor ( )

( ) Yes ( ) No

Are you allergic to any drugs, medicines or shots? If so, which?

( ) Yes ( ) No

Are you taking any medications? If so, which? \_\_\_\_\_

( ) Yes ( ) No

Do you have a history of the following:

( ) Heart Problems ( ) Urinary tract infection ( ) MVP  
( ) Intestinal Problems ( ) Esophagitis ( ) Thyroid  
( ) Kidney Problems ( ) Pneumonia ( ) Diabetes  
( ) Gastric Reflux ( ) Headaches ( ) Asthma

( ) Yes ( ) No

Is premedication necessary prior to dental procedures due to heart problems?

( ) Yes ( ) No

Have you had any surgery(ies)? If so, please describe briefly.

( ) Yes ( ) No

Any blood transfusions?

( ) Yes ( ) No

Any complications? If so, please describe \_\_\_\_\_

( ) Yes ( ) No

Have you ever been treated for cancer? Leukemia? Multiple Myeloma?

( ) Yes ( ) No

Do you have any problems with your immune system?

( ) Yes ( ) No

Have you ever been tested for HIV infection?

( ) Yes ( ) No

Have you had any psychological counseling?

( ) Yes ( ) No

Have you ever sucked your thumb or finger? Until what age? \_\_\_\_\_

( ) Yes ( ) No

Do you have any speech problems?

( ) Yes ( ) No

Do you breathe through your mouth while awake?

( ) Yes ( ) No

Do you breathe through your mouth while asleep?

( ) Yes ( ) No

Is there any lip or nail biting?

( ) Yes ( ) No

Have you been informed of any missing or extra permanent teeth?

( ) Yes ( ) No

Has an orthodontist been consulted previously?

( ) Yes ( ) No

Have you had orthodontic treatment? Who was your orthodontist?

( ) Yes ( ) No

Do you vomit, gag or faint easily?

( ) Yes ( ) No

Has any pain been experienced in or near the ears?

( ) Left ( ) Right

( ) Yes ( ) No

Do you have a history of TMJ problems?

( ) Yes ( ) No

Has there been any apprehension or unfavorable experience in a dental office?

( ) Yes ( ) No

Have you gone through a preventive program with your dentist, cleanings and check-ups?

When was your last visit to the dentist? \_\_\_\_\_

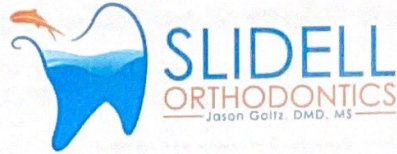
List any musical instruments played by mouth \_\_\_\_\_

What problems are you concerned with on your teeth?

Signature (Parent's signature if minor) \_\_\_\_\_ Date \_\_\_\_\_



## Receive Text & Email



You can:

- Receive appointment reminders, so you can confirm your appointments online.
- Receive appointment text reminders, so you can confirm your appointments via text.
- Receive our quarterly newsletter with articles about orthodontic and dental topics, and the news about our office!
- Check your account online with our office.

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Patient's name: \_\_\_\_\_

Responsible Party's name: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient's Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Responsible Party's Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient's Email Address: \_\_\_\_\_

Responsible party's Email Address: \_\_\_\_\_

I, \_\_\_\_\_, give permission to have text

reminders sent to these cell phones. Signature: \_\_\_\_\_

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Date \_\_\_\_\_

**Patient Information**

Patient's Name \_\_\_\_\_  
Last First Name Prefer to be Called Middle In.

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Social Security# \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

Whom may we thank for referring you to our office? \_\_\_\_\_ General Dentist \_\_\_\_\_

Family member in or out of orthodontic treatment \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_ How Long? \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Orthodontic Insurance Information Only**

Insured's Name \_\_\_\_\_ Insured's SS# or ID# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes:

Insured's Name \_\_\_\_\_ Insured's SS# or ID# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_