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

SLIDELL ORTHODONTICS
Jason Goltz, DMD, MS

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.

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: _____

Date _____

Patient Information

Patient's Name _____
Last First Name Prefer to be Called Middle Init.

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 _____