ORTHODONTIC PATIENT INFORMATION

Welcome to our office,

The following information is requested to enable us to give the best consideration of your orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information, important for our records and your health, is confidential.

Thank you.

Patient's Name ______________________ Birthdate ____________
Home address ______________________ E-mail ____________
City ____________ State ________ Zip ________ Telephone ____________
Business address ______________________
City ____________ State ________ Zip ________ Telephone ____________ Ext. ______
Occupation ______________________
Name of Spouse ______________________ Married ________ Single ________
Family physician's name ______________________
Address ______________________
Dentist's name ______________________
Address ______________________ Telephone # ____________
Referred by ______________________
Name of Dental Insurance Company ______________________
Social Security # ______________________

IN THE FOLLOWING QUESTIONS, PLEASE CIRCLE YES OR NO.

1. Are you in good health? .... YES NO
2. Has there been any change in your general health within the past year? .... YES NO
3. My last physical examination was on ______________________
4. Are you now under the care of a physician? .... YES NO
   a. If so, what is the condition being treated ______________________
5. The name and address of the physician treating this condition is ______________________
   ____
6. Have you had any serious illness or operation? .... YES NO
   a. If so, what was the illness or operation? ______________________
7. Have you been hospitalized or had a serious illness within the past five (5) years? .... YES NO
   a. If so, what was the problem? ______________________
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves .... YES NO
   b. Congential heart lesions .... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .... YES NO
   d. Sinus trouble .... YES NO
   e. Asthma or hay fever .... YES NO
   f. Hives or a skin rash .... YES NO
   g. Fainting spells or seizures .... YES NO
   h. Diabetes .... YES NO
   i. Hepatitis, jaundice or liver disease .... YES NO
   j. Arthritis .... YES NO
   k. Inflammatory rheumatism (painful swollen joints) .... YES NO
   l. Stomach ulcers .... YES NO
   m. Kidney trouble .... YES NO
   n. Tuberculosis .... YES NO
   o. Do you have a persistent cough or cough up blood? .... YES NO
   p. Low blood pressure .... YES NO
   q. Venereal disease .... YES NO
   r. AIDS (ARC) .... YES NO
   s. Other ______________________

(over)

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? .... YES NO
   a. Do you bruise easily? .... YES NO
   b. Have you ever required a blood transfusion? .... YES NO
   If so, explain the circumstances ________________________________

10. Do you have any blood disorder such as anemia? .... YES NO
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? YES NO
12. Are you taking any drug or medicine? .... YES NO
    If so, what? ________________________________
13. Are you taking any of the following:
    a. Antibiotics or sulfa drugs .... YES NO
    b. Anticoagulants (blood thinners) .... YES NO
    c. Medicine for high blood pressure .... YES NO
    d. Cortisone (steroids) .... YES NO
    e. Tranquilizers .... YES NO
    f. Antihistamines .... YES NO
    g. Aspirin .... YES NO
    h. Insulin, tolbutamide (Orinase) or similar drug .... YES NO
    i. Digitalis or drugs for heart trouble .... YES NO
    j. Nitroglycerin .... YES NO
    k. Oral contraceptive or other hormonal therapy .... YES NO
    i. Other ________________________________
14. Are you allergic or have you reacted adversely to:
    a. Local anesthetics .... YES NO
    b. Penicillin or other antibiotics .... YES NO
    c. Sulfa drugs .... YES NO
    d. Barbiturates, sedatives, or sleeping pills .... YES NO
    e. Aspirin .... YES NO
    f. Iodine .... YES NO
    g. Codeine or other narcotics .... YES NO
    h. Other ________________________________
15. Have you had any serious trouble associated with any previous dental treatment? .... YES NO
    If so, explain ________________________________

16. Do you have any disease, condition, or problem not listed above that you think we should know about ..... YES NO
    If so, explain ________________________________

17. Have you been in contact with anyone at risk for the following:
    a. Herpes .... YES NO
    b. Hepatitis .... YES NO
    c. Tuberculosis .... YES NO
    d. AIDS (ARC) .... YES NO

WOMEN

18. Are you pregnant? .... YES NO
19. Do you have any problems associated with your menstrual period? .... YES NO
20. Are you nursing? .... YES NO

DENTAL HISTORY:

21. Have you had any teeth extracted? .... YES NO
    How long ago? __________ Reason for extraction ________________________________
22. Have any teeth been injured due to accidents or trauma to the mouth? .... YES NO
23. Have you ever had periodontal treatment? .... YES NO
24. Do you clench or grind your teeth? .... YES NO
25. Do you have pain or clicking in your jaw joint when chewing? .... YES NO
26. The date of your last dental check-up? ________________________________
    At that time, were the teeth cleaned? .... YES NO
27. Have you had previous orthodontic consultations or treatment? .... YES NO
    Date __________ Dr. ________________________________
28. What is your primary reason for seeking orthodontic treatment?
____
____

Date __________ Signature ________________________________