

Personal Medical and Dental History

Today's date: _____

Your careful and complete answers to the following questions will be helpful in the evaluation of your orthodontic condition. Please print.

Patient's name _____	Nickname _____
Mailing address _____	
City, State, Zip _____	
Patient/Parent e-mail address _____	
Home Phone (____) _____	Work Phone (____) _____
Date of Birth _____	Present Age _____ years _____ months
Referred to our office by _____	
Name of individual completing this form _____	
Relationship to patient _____	

Patient's Social Security Number _____ - _____ - _____

Patient's Place of Employment _____

Employer's Address _____

General Dentist's Name _____ Date of last cleaning _____

Address _____

Physician's Name _____

Address _____

How is the patient's general health now? _____

List illnesses other than usual childhood disease _____

At what age they occurred _____

List injuries or operations of the head and neck _____

At what age did they occur? _____

List all allergies (including drug allergies) _____

So that we may take future growth potential into account, please indicate if the patient has not started puberty ____, is going through puberty right now ____, is past puberty ____.

Please check and comment on the following that are applicable to the patient:

- | | | |
|--|---|---|
| <input type="checkbox"/> Tubes in ears | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Mouth breathing (awake/asleep) |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart, Blood | <input type="checkbox"/> Special Diets |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleeplessness |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Upsets |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Gagging, Nausea | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> (Women) Are you pregnant? | | |

Noticeable change in weight or height in the past year Yes___ No___

Please continue with questions on reverse side

Currently taking medication or under a doctor's care Yes___ No___
If yes, please list _____

Grind or clench teeth at night Yes___ No___

Bite lips, nails, pencils, tongue, thumb Yes___ No___

Prone to ear aches Yes___ No___

Soreness around the ears Yes___ No___

Clicking/popping of joint in front of ear upon opening/closing Yes___ No___

Removal of supernumerary (extra) teeth Yes___ No___

Fractured teeth Yes___ No___

If yes, when? _____

Removal of baby or permanent teeth by dentist Yes___ No___

If yes, when? _____

Previous orthodontic treatment or consultation Yes___ No___

Closely related family member with similar problems Yes___ No___

If yes, please explain _____

Has patient ever had extensive x-ray therapy? Yes___ No___

Has anyone else in patients' family worn braces? Yes___ No___

If yes, has result been satisfactory? _____

Patient's facial structure resembles mother _____ or father _____

Both parents have a positive attitude toward orthodontics Yes___ No___

Patient's brothers and sisters:

NAME	BIRTHDATE	Do they also have orthodontics needs?	
_____	_____	Yes___	No___
_____	_____	Yes___	No___
_____	_____	Yes___	No___

School patient attends _____ Grade _____

Patient's hobbies or interests _____

Father's name _____ Father's Social Security Number _____

Father's mailing address _____

Father's Home Phone (____) _____ Work (____) _____ Occupation _____

Mother's name _____ Mother's Social Security Number _____

Mother's mailing address _____

Mother's Home Phone (____) _____ Work (____) _____ Occupation _____

Name of person(s) responsible for this account _____ Relationship to patient _____

Dental Insurance Provider _____

Claims Address _____

Insured Person _____ SS# ____-____-____ Group# _____

Employer _____ Employer Address _____

