Kurt Kavanaugh Orthodontics – Personal Medical and Dental History

Kansas City Location – 8407 N. Main Street, Kansas City, MO 64155 – 816-420-8100
Sedalia Location – 4400 S. Limit, Sedalia, MO 65301 – 660-829-2900

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 (____) _____ Cell (____) _____ Work (____) _____

Date of Birth _____ Present Age _____years _____months

Patient's Social Security Number _____-_____-_____

School patient attends _____

Patient's Place of Employment _____

Employer's Address _____

Name of individual completing this form _____Relationship to patient _____

Who to contact in case of an emergency _____Phone _____

Referred to our office by _____

Patient's hobbies or interests _____

General Dentist's Name _____ Date of last cleaning_____

Address _____

Physician's Name _____

Address _____

(Please fill out the following if the patient is a minor)

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

Father's mailing address _____

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

Occupation _____ Father's Date of Birth _____

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

Mother's mailing address _____

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

Occupation _____ Mother's Date of Birth _____

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

Please continue with question on reverse side

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:

___ Tubes in ears	___ Sinus trouble	___ Mouth breathing (awake/asleep)
___ Rheumatic Fever	___ Heart, Blood	___ Special Diets
___ Convulsions	___ Asthma	___ Sleeplessness
___ Hepatitis	___ Headaches	___ Digestive Upsets
___ High Blood Pressure	___ Contact Lenses	___ Kidney Problems
___ Gagging, Nausea	___ Tuberculosis	___ Diabetes

___ (Women) Are you pregnant?

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

Mail, Fax or Email all forms to: **Kurt Kavanaugh Orthodontics**
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