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## Medical History

Do you have a personal physician?  Yes  No  
 Physician's name: \_\_\_\_\_  
 Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Your current physical health is:  Good  Fair  Poor  
 Are you currently under the care of a physician?  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 Are you taking any prescription/over-the-counter drugs?  Yes  No  
 If yes, please list each one: \_\_\_\_\_  
 (Women) Are you pregnant?  Yes  No If yes, week #: \_\_\_\_\_

Have you ever had any of the following diseases or medical problems?

	YES	NO		YES	NO
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery/Pacemaker....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial bones/joints/valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	High/Low blood pressure....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization (any).....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defect .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia/Osteoporosis....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol abuse .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Severe/Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures/Fainting .....	<input type="checkbox"/>	<input type="checkbox"/>	Shingles .....	<input type="checkbox"/>	<input type="checkbox"/>
Fever blisters/Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Tonsil/Adenoid condition .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB).....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Colitis.....	<input type="checkbox"/>	<input type="checkbox"/>

Please list any serious medical condition(s) that you have ever had:  
 \_\_\_\_\_

Are you allergic to any of the following:

	YES	NO		YES	NO
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin.....	<input type="checkbox"/>	<input type="checkbox"/>
Any metals/plastics.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>
Dental anesthetics .....	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline .....	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other drugs/materials that you are allergic to:  
 \_\_\_\_\_

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## Dental History

What are the concerns that you would like orthodontic treatment to accomplish? \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had or been evaluated for orthodontic treatment? .....  Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work? .....  Yes  No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? .....  Yes  No

Your current dental health is: .....  Good  Fair  Poor

Do you like your smile? .....  Yes  No

Do your gums ever bleed? .....  Yes  No

Have you ever had an injury to your...  Mouth  Teeth  Chin

Any speech problems? .....  Yes  No  
 If yes, what? \_\_\_\_\_

Do you generally breathe through your mouth? .....  Yes  No

If yes, when? .....  While awake  While asleep

Any missing or extra permanent teeth? .....  Yes  No

Do you need antibiotic premedication/coverage prior to dental procedures? .....  Yes  No

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## Consent

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize insurance payments to my attending orthodontists. I understand that I am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDA and the ADA, as well as adhering to the privacy policies set forth by the HIPAA Act of 1996.

### — FOR OFFICE USE ONLY — — FOR OFFICE USE ONLY — — FOR OFFICE USE ONLY —

I verbally reviewed the medical/dental information above with the patient named herein.

Orthodontist's or Treatment Coordinator's comments: \_\_\_\_\_  
 \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Update: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_