MEDICAL AND DENTAL HISTORY

Patient information

Date___________________________

Patient's Name____

Birthdate_________Age______Sex___

Married ▢Single▢ Spouse Name________________________________

Spouse Phone____________________

Street Address____

Home Phone_____________________

City______________________________ Zip Code___________________

Cell Phone______________________

Employer/Occupation____

Work Phone_____________________

Responsible Party Email____

FAMILY INFORMATION (If patient is a minor)

Father____

Home Phone___________________

Address____

Cell Phone ____________________

Employer/Occupation____

Work Phone____________________

Mother____

Home Phone___________________

Address____

Cell Phone_____________________

Employer/Occupation____

Work Phone____________________

Married ▢ Divorced ▢Separated ▢ Patient lives with____

FINANCIAL INFORMATION

Our office does not accept assignment or insurance benefits and it is our financial policy that responsibility for payment lies with the patient. Reimbursement from insurance benefits will be paid directly to you.

Person responsible for account____SS#___________________

(a credit report will be run to determine "In-House" financing options, following the Diagnostic Records appointment)

Do you have orthodontic insurance: ▢ N ▢ Y If yes, please complete the insurance form.

DENTAL HISTORY

Patient's reason for seeking orthodontic treatment____

Patients dentist_____________________________City_____________________________Date of last visit____________

Comments on any Dental Trauma____

Previous Orthodontic treatment? N ▢ Y▢ Length of treatment___________months

Orthodontist name and address____

Who referred you to this office?____

Patient's school____ Grade___________________________________

Patient's hobbies____Is patient adopted?________________________

Does the family anticipate moving out of the area in the next 2-3 years? N ▢ Y ▢

	Circle One			Circle One	
Clench the teeth	Y	N	Have difficulty in cleaning the teeth	Y	N
Grind the teeth	Y	N	Still have adenoids	Y	N
Chew or suck on the fingers or lip	Y	N	Still have tonsils	Y	N
Have speech problems	Y	N	Have any pain in the face	Y	N
Have frequent headaches	Y	N	Noticed any clicking near the ears	Y	N
Have difficulty in opening the mouth	Y	N	Have noise or popping in jaw joint	Y	N
Had any TMJ treatment	Y	N	Ever worn a mouth guard or splint	Y	N
Breathe through the mouth	Y	N	Difficulty breathing thru the nose	Y	N
Had any dental extractions	Y	N	Had any teeth knocked out	Y	N
Had any injuries to the jaws or teeth	Y	N	Fallen on the face	Y	N
Had any surgery on the face or jaws	Y	N	Experienced bleeding gums	Y	N
Had any gum problems	Y	N	Had mouth sores	Y	N
Had any previous orthodontic treatment	Y	N	Had any difficult dental treatment	Y	N

Medical History

Patient's Physician ______________________________City ____________________Date of last visit ______________

	Circle One	
Has the patient been under a physician's care during the last five years?	Y	N
Has the patient been hospitalized or had any serious illness?	Y	N
Has the patient had any reactions to local or general anesthesia?	Y	N
Has the patient had any change in health in the past five years?	Y	N
Has the patient experienced excessive bleeding with dental or surgical treatment?	Y	N
Is the patient allergic to any medication or substance?	Y	N

If yes, name the medication or substances ____

Name any medications the patient is currently taking ____

Has the patient contracted any the following conditions:

Abnormal Bleeding	Y	N	Emotional problems	Y	N	Lung disease	Y	N
AIDS/ARC	Y	N	Endocrine disturbance	Y	N	Mental Problems	Y	N
Allergies	Y	N	Epilepsy	Y	N	Pacemaker	Y	N
Anemia	Y	N	Excessive thirst	Y	N	Persistent cough	Y	N
Ankle swelling	Y	N	Excessive weight loss	Y	N	Persistent fever	Y	N
Arthritis	Y	N	Fainting spells	Y	N	Pregnancy (currently)	Y	N
Asthma	Y	N	Growth disturbance	Y	N	Prosthetic heart valve	Y	N
Auto accident injury	Y	N	Hearing problems	Y	N	Prosthetic joint	Y	N
Behavioral problems	Y	N	Heart disease	Y	N	Radiation therapy	Y	N
Birth defects	Y	N	Heart murmur	Y	N	Rheumatic fever	Y	N
Bone disease	Y	N	Hemodialysis	Y	N	Rickets	Y	N
Brain illness	Y	N	Hemophilia	Y	N	Scarlet fever	Y	N
Breathing problems	Y	N	Hepatitis	Y	N	Severe headaches	Y	N
Bruise easily	Y	N	Herpes	Y	N	Shortness of breath	Y	N
Cancer	Y	N	High blood pressure	Y	N	Skin rash or sores	Y	N
Chemotherapy	Y	N	HIV	Y	N	Stroke	Y	N
Chest pain	Y	N	Injured during sports	Y	N	Swollen glands	Y	N
Chronic pain	Y	N	Intravenous injections	Y	N	Thyroid disease	Y	N
Convulsions	Y	N	Kidney disease	Y	N	Tobacco use in any form	Y	N
Diabetes	Y	N	Liver disease	Y	N	Tuberculosis	Y	N
Dizziness	Y	N	Low blood pressure	Y	N	Ulcers	Y	N
Drug abuse	Y	N						

Are there any other conditions an orthodontist or oral surgeon should know about? ______________________________
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SIGNATURE OF PERSON FILLING OUT FORM____
RELATIONSHIP TO PATIENT______________________________**DATE**______________

POOL ORTHODONTICS