

Why have you come to the dentist today, _____

Have you experienced problems with previous dental work? Yes No

Is your water fluoridated? Yes No

Are you taking fluoridated supplements? Yes No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? Yes No

Do you brush your teeth daily? Yes No

Floss your teeth daily? Yes No

Do your gums bleed? Yes No

Do you require antibiotics before dental work? Yes No

Have you ever taken Phen-Fen? Yes No
Also known as Redux or Pondimin. If so, when? _____

Are you currently under a physician's care? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Please describe your current physical health:
 Good Fair Poor

Please list all drugs that you are currently taking: _____

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Unsure Week #: _____

Are you nursing? Yes No

For orthodontic treatment please complete the following:

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated/had orthodontic treatment before? Yes No

Have there been any injuries to your face, mouth, teeth or chin? Yes No

Have adenoids or tonsils been removed? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Do you still have your wisdom teeth? Yes No

Have you played any musical instruments? Yes No
If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin

Y N Any Metal / Jewelry

Y N Plastic

Y N Codeine

Y N Dental Anesthetics

Y N Erythromycin

Y N Latex

Y N Penicillin

Y N Tetracycline

Y N Other

Please list any other Allergies that you have _____

DID/DO YOU HAVE ANY OF THE FOLLOWING HABITS?

Y N Nursing Bottle Habits

Y N Speech Problems

Y N Thumb / Finger Sucking

Y N Tongue Thrust

Y N Clenching / Grinding Teeth

Y N Lip Sucking / Biting

Y N Mouth Breather

Y N Nail Biting

Y N Were you breastfed?

Y N Used Pacifier?

Are your Immunizations current? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abnormal Bleeding

Y N Anemia

Y N Any Hospital Stays

Y N Artificial Bones / Joints

Y N Asthma

Y N Cancer

Y N Chicken Pox

Y N Congenital Heart Defect

Y N Convulsions / Epilepsy

Y N Diabetes

Y N Exposed to HIV, but Neg.

Y N Handicaps / Disabilities

Y N Hearing Impairment

Y N Heart Murmur

Y N Hemophilia

Y N Hepatitis

Y N Hives

Y N HIV+ / AIDS

Y N Kidney Problems

Y N Liver Problems

Y N Measles

Y N Mononucleosis

Y N Mitral Valve Prolapse

Y N Rheumatic / Scarlet Fever

Y N Skin Rash

Y N Tuberculosis (TB)

Please discuss any serious medical problems you've experienced:

Is there anything you would like to discuss with the doctor in private? Yes No

I understand that I am responsible (If 18 yrs or older) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover.

Patient Signature _____ Date _____

Parent/Guardian Signature (If Necessary) _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature of Patient and/or Parent/Guardian _____ Date _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of Patient and/or Parent/Guardian _____ Date _____

The Patient or Parent/Guardian is responsible for payment at time of service unless prior arrangements have been approved.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: ____/____/____
Doctor's Comments: _____