Medical/Dental History

EMAIL: _____ Date: _____

Patient's Name: Sex: Age: Birthdate:

Prefers to be addressed by: Referred by:

Address: City: Zip: Phone:

Father's Name: Occupation: Work Phone:

Father's Employer:

Mother's Name: Occupation Work Phone:

Mother's Employer Parent's Marital Status: ☐Married ☐ Single ☐Divorced☐Separated ☐ Widowed

Siblings Name: DOB: Siblings Name: DOB:

Siblings Name: DOB: Siblings Name: DOB:

Guardian: Home Phone:

Guardian's Employer: Occupation: Work Phone:

Person Responsible for Account: ☐Father ☐Mother ☐ Other (State Name):

Address: Business Phone: Home Phone:

DENTAL INSURANCE

Primary Insurance Co: Gr. #: Ortho. Coverage: YES NO

Insureds Name: SS#: Birthdate:

Secondary Insurance Co: Gr. #: Ortho. Coverage: YES NO

Insureds Name: SS#: Birthdate:

Other Insurance Information:

DENTAL HISTORY

Patient's Dentist: Date of Last Visit:

1. Have there been any injuries to the face, mouth or teeth? YES NO
2. Has the patient had or presently have any of the following habits? YES NO Thumb or finger sucking Lip Biting Snoring Grinding of teeth at night Mouth breathing
3. Has the patient been informed of any missing or extra permanent teeth? YES NO
4. Is the patient aware of sores, lumps or irritated areas in the mouth? YES NO
5. Has an orthodontist been consulted previously? YES NO
   Name: Date:
6. Has the patient ever been treated for: YES NO Bad Bite TMJ Periodontal disease
   If so, by whom:
7. Does the patient have any speech problems? YES NO
8. Is the patient frightened or anxious about Orthodontic treatment? YES NO
9. Is the patient concerned about the appearance of their teeth? YES NO
10. Is there anything the patient would like to change about his/her smile? YES NO
    If so, what:
11. What aspect of dental treatment is the patient most concerned with? Quality Cost Discomfort Time
12. Reason for consultation:
13. Has there ever been any orthodontic treatment for any other member of the family YES NO
    Are you satisfied with the results? YES NO
    Mother (Dr. _____) Father (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)

MEDICAL HISTORY

1.	Is the patient's general health good at this time?	YES NO
2.	What is the name of the family physician?	Date of last physical exam:
3.	Is the patient under the care of a physician at this time? Explain:	YES NO
4.	Is the patient taking any medication? Name:	YES NO
5.	Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name:	YES NO
6.	Has the patient had tonsils and adenoids removed? Age:	YES NO
7.	Has the patient ever had a serious illness or been hospitalized? Explain:	YES NO
8.	Does the patient have any special problems not listed? Explain:	YES NO
9.	Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? If yes, antibiotic name and method:	YES NO
10.	What is the patient's approximate height?	Weight?
11.	Has the patient shown signs of increased growth recently?	YES NO
12.	Has the patient reached puberty? Girls – started menstruating? Boys – voice changed?	YES NO YES NO YES NO
13.	Father's present height: _____ Older brother's present height: _____	Mother's present height: _____ Older sisters present height: _____

Does the patient now, or have they ever had any of the following?

YES NO Endocarditis	YES NO Respiratory Lung Disease	YES NO Glaucoma	MEMO:
YES NO Heart Condition	YES NO High Blood Pressure	YES NO Fainting Spells	
YES NO Heart Pacemaker	YES NO Low Blood Pressure	YES NO Kidney Trouble	
YES NO Heart Angina	YES NO Hepatitis (type?_____)	YES NO Liver Disease	
YES NO Heart Attack (coronary)	YES NO Tuberculosis	YES NO Psychiatric Treatment	
YES NO Mitral Valve Prolapse	YES NO Venereal Disease	YES NO Drug Addiction	
YES NO Congenital Heart Disease	YES NO Herpes (oral-cold sores)	YES NO Headaches	
YES NO Artificial Heart Valve	YES NO Blood Disorders/Bleeding Problems	YES NO Earaches	
YES NO Heart Surgery; date_____	YES NO Inflammatory Rheumatism	YES NO Jaw Clicking	
YES NO Heart Murmur	YES NO Arthritis	YES NO Allergies	
YES NO Rheumatic Fever	YES NO Ulcers	YES NO Jaw Pain	
YES NO Prosthetic (artificial) Joint	YES NO Stroke	YES NO Tonsillitis	
YES NO X-Ray/Radiation (cancer) Therapy	YES NO Anemia	YES NO Emotional Problems	
YES NO AIDS or H.I.V. Positive	YES NO Asthma	YES NO Other:_____	
YES NO Diabetes	YES NO Epilepsy	_____	

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.

Signature of patient or parent or guardian

_____ Date: _____

Signature of Mark P. Brieden, DDS, MS or Lathe Miller, DDS, MS

_____

Update_____ Initial____

Update_____ Initial____

Update_____ Initial____

Update_____ Initial____

Update_____ Initial____

NOTES: