# PATIENT HISTORY

**PATIENT INFORMATION**

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ Parent Name(s): _____

Home Phone: _____ Hobbies: _____

Referred by: _____ Dentist: _____

Family members in treatment here: _____

Has the patient had previous orthodontic consultation or treatment? ☐ Yes ☐ No

Please specify: _____

Is the patient aware of any orthodontic problem? ☐ Yes ☐ No

What is the patient's attitude toward teeth, face, and orthodontic treatment?

Does the patient have regular dental checkups? ☐ Yes ☐ No

Date of last checkup: _____ Were the patient's teeth cleaned? ☐ Yes ☐ No

Patient's interest in orthodontic treatment: ☐Wants treatment ☐If necessary ☐Unwilling but agrees ☐Uncooperative

Orthodontic consult prompted by: ☐Patient ☐Dentist ☐Mother ☐Father ☐Spouse ☐Friend ☐Other

Please specify: _____

Why did the patient seek this consultation? _____

What is expected from orthodontic treatment? _____

Any history of head, jaw, or facial injuries? ☐ Yes ☐ No Please explain: _____

_____

Does your jaw pop, click, or have ever caused you any pain? ☐ Yes ☐ No

Do you snore at night? ☐ Yes ☐ No Do you have restful sleep? ☐ Yes ☐ No

Please specify: _____

Has the patient had any unusual dental experiences? ☐ Surgery ☐ Extraction(s) ☐ Bridges ☐ Implants ☐ Other

Are there any dental problems not covered above? ☐ Yes ☐ No

Additional comments: _____

I understand that the information that I have given today is correct and true to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I certify and agree (regardless of my insurance status) that I am ultimately responsible for the balance on my account for any professional services rendered.

Signature of individual completing this form: _____ Date: _____

Relationship to patient: _____

**MEDICAL HISTORY**

Patient Name: _____ Date of Birth: _____

**PLEASE CIRCLE ALL THAT APPLY:**

**Respiratory Conditions:** ☐ Yes ☐ No
- Asthma
- Apnea
- Emphysema
- Other: _____

**Cardiac Conditions:** ☐ Yes ☐ No
- Artificial Heart Valve
- Heart Attack
- High Blood Pressure
- Low Blood Pressure
- Mitral Valve Prolapse
- Pacemaker
- Heart Murmur
- Antibiotic Prophylaxis Indicated ☐ Yes ☐ No
- Other: _____

**Liver Conditions:** ☐ Yes ☐ No
- Hepatitis (circle) A B C
- Cirrhosis
- Alcohol Abuse
- Other: _____

**Blood Disorders:** ☐ Yes ☐ No
- Anemia
- Abnormal Bleeding
- Hemophilia
- Leukemia
- Sickle Cell Anemia
- Other: _____
- _____

**Cancer:** ☐ Yes ☐ No
- Type: _____
- Radiation
- Chemotherapy

**Other:**
- Diabetes
- Epilepsy
- Seizures
- Stroke
- Thyroid Disorders
- STD Type: _____
- Tuberculosis
- Psychiatric Conditions
  Type: _____
- Osteoporosis

**Allergies:** ☐ Yes ☐ No
- Metals: _____
- Latex
- Jewelry
- Dental Anesthetics
- Seasonal
- Other: _____

**Medications:** ☐ Yes ☐ No
- Please list: _____
- _____

**IF FEMALE PLEASE ANSWER**

Pregnant ☐ Yes ☐ No Nursing ☐ Yes ☐ No

Please list any other surgeries/medical issues not covered above: _____

_____

_____

Doctor comments: _____

_____

_____

Signature of individual completing this form: _____ Date: _____

Relationship to patient: _____