

MEDICAL HISTORY

Patient Name _____ Sex _____ Age _____

Please circle "Yes" or "No" to the following questions:

1. Have you ever been hospitalized overnight? If yes, why? _____ Yes _____ No
2. Have you ever had surgery? If yes, explain. _____ Yes _____ No
3. Are you taking any medications? Are you taking any medications that have been prescribed for you? _____ Yes _____ No
If so, do any medications include treatment for osteoporosis? (i.e. Fosamax, Boniva, Etc.) _____ Yes _____ No
Are you taking any medications for Blood Clotting? (i.e. Coumadin, etc.) _____ Yes _____ No
If yes, please list what you are taking and the purpose _____

4. Are you allergic to anything? Have you ever had an allergic reaction to penicillin? Another antibiotic? Codeine? Aspirin? Local anesthetic? Latex allergy? _____ Yes _____ No
5. Have you ever had rheumatic fever? Rheumatic heart disease? A heart murmur? Mitral valve prolapse? Systemic lupus erythematosus? Congenital heart disease Bacterial endocarditis? _____ Yes _____ No
6. Do you have any heart problems, chest pains or angina? Have you ever had a heart attack or heart surgery? _____ Yes _____ No
7. Do you have high blood pressure? _____ Yes _____ No
Diabetes? _____ Yes _____ No
Thyroid Problems? _____ Yes _____ No
8. Do you have a bleeding problem? Do you bruise easily? Have you ever had a bleeding problem following oral surgery or any surgery? Do you have any family history of bleeding problems? _____ Yes _____ No
9. Have you had any problems with your liver or do you have chronic hepatitis? _____ Yes _____ No
10. Have you ever been treated for cancer? Leukemia? Multiple myeloma? Lymphoma? _____ Yes _____ No
11. Do you have any problems with your immune system? Have you ever been tested for HIV infection? _____ Yes _____ No
12. Do you have asthma or any other breathing problems? _____ Yes _____ No
13. Have you ever had seizures or a stroke? _____ Yes _____ No
14. FEMALES: Has patient begun menstruation? (if Yes, when? _____) _____ Yes _____ No
Are you pregnant or breast feeding? _____ Yes _____ No
15. Do you have any kidney problems? Are you on kidney dialysis? Have you had a kidney transplant? _____ Yes _____ No
16. Do you have arthritis, "rheumatism", or joint pain? _____ Yes _____ No
17. Do you have any other medical condition not listed above? _____ Yes _____ No
If so, please explain _____
18. Who is your physician? _____ Address _____

Signature (parent if patient is a minor) _____

_____ date

Patient Information

Patient's Name _____
Last First Name Prefer to be Called Middle Init.

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Sex _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____ General Dentist _____

Family member in or out of orthodontic treatment _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Cell Phone _____

Previous Address (if less than 3 yrs.) _____ How long? _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Orthodontic Insurance Information Only

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insurance Co. Phone _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

Updates (date & initial) _____