

DENTAL HISTORY

Dentist: _____ Date of Last Dental Exam: _____

Circle (Yes / No) if you / your child have had problems with any of the following:

Bad Breath	Yes / No	Bleeding Gums	Yes / No	Jaw Clicking, popping, Locking	Yes / No
Sensitivity to cold	Yes / No	Sensitivity to hot	Yes / No	Food collecting between teeth	Yes / No
Sensitivity to sweets	Yes / No	Loose/Broken teeth	Yes / No	Grinding/Clenching teeth	Yes / No
Sores in mouth	Yes / No	Mouth Breathing	Yes / No	Periodontal Treatment	Yes / No
Snoring	Yes / No	Nail Biting	Yes / No	Thumb/Finger Sucking	Yes / No

Any injuries to mouth or chin injury Yes / No If yes, please explain: _____

Have you / your child ever been evaluated for orthodontic treatment? Yes / No Orthodontist: _____

MEDICAL HISTORY

Physician's Name: _____ Phone #: _____

Any recent illness (or) surgeries Yes / No If yes, describe: _____

Are you / your child currently under physician care Yes / No If yes, describe: _____

Do you / your child still have: Tonsils Yes / No Adenoids Yes / No

Women: Are you pregnant? Yes / No Taking birth control? Yes / No

Circle (Yes / No) whether you / your child have (or) has any of the following:

AIDS/HIV+	Yes / No	Hepatitis	Yes / No	High Blood Pressure	Yes / No	Stroke	Yes / No
Diabetes	Yes / No	Kidney Disease	Yes / No	Heart Murmur	Yes / No	Asthma	Yes / No
Liver Disease	Yes / No	Hemophilia	Yes / No	Heart Attack	Yes / No	Cancer	Yes / No
Jaw Pain	Yes / No	Epilepsy	Yes / No	Congenital Heart Def	Yes / No	Fainting	Yes / No
Sinus Prob.	Yes / No	Tuberculosis	Yes / No	Drug/Alcohol Abuse	Yes / No	Headaches	Yes / No
Cold Sores	Yes / No	Rheum Fever	Yes / No	Mitral Valve Prolapse	Yes / No	Anaphylaxis	Yes / No

Are you / patient taking any medication for your bones? Yes / No If yes, List: _____

Are you / patient currently taking any medications? Yes / No If yes, List: _____

Does Patient have any drug allergies? If yes, List all: _____

Allergic to LATEX Yes / No

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my / my child's medical status. I also authorize the orthodontic staff to perform the necessary orthodontic services I / my child may need.

Signature of Parent / Guardian: _____ Date: _____

The parent, guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.