Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician Name: _____

Physician Phone Number: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If Yes, Please explain:

Do you smoke or use tobacco of any kind? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/ over the counter drugs? ☐ Yes ☐ No

If yes, Please list each one: _____

_____

_____

Have you even taken Phen-Fen? Also known as Redux or Pondimin? ☐ Yes ☐ No

If yes, when? _____

Have you ever taken a Bisphosphonate For Osteoporosis such as Bonivia? Fosamax, Actonel, Skelid, Zometa? ☐ Yes ☐ No

If Yes, How long have you taken it? _____

Or how long have you been off of it? _____

For Women

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If yes, How many weeks?

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases/medical problems?

☐Y ☐ N Abnormal bleeding/ Hemophilia
☐ Y ☐ N AIDS/ HIV
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis
☐ Y ☐ N Artificial Bones/ Valves
☐ Y ☐ N Asthma
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Cancer/ Chemotherapy
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Diabetes
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Emphysema
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Frequent Headaches
☐ Y ☐ N Glaucoma
☐ Y ☐ N Hay Fever
☐ Y ☐ N Herpes/ Fever Blister
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Hospitalized for any reason
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mitral Valve Problems
☐ Y ☐ N Osteoporosis/ Osteopenia
☐ Y ☐ N Pacemaker
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Rheumatic/ Scarlet Fever
☐ Y ☐ N Seizures
☐ Y ☐ N Shingles
☐ Y ☐ N Sickle Cell Disease/ Traits
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Stroke
☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Tuberculosis (TB)
☐ Y ☐ N Ulcers

Medical History

Are you allergic to any of the following?

☐Yes ☐ No Aspirin
☐Yes ☐ No Codeine
☐Yes ☐ No Dental Anesthetics
☐Yes ☐ No Erythromycin
☐Yes ☐ No Jewelry/ Metals
☐Yes ☐ No Latex
☐Yes ☐ No Penicillin
☐Yes ☐ No Tetracycline
☐Yes ☐ No Other

List any other drugs/ materials you are allergic to: _____

_____

_____

Dental History

What are the main concerns you would like to address?_____

_____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

If Yes, Have you ever had braces before? ☐ Yes ☐ No

When and Where? _____

_____

_____

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/ difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Have you ever had injury to your (circle one): Mouth/ Teeth/ Chin

Do you have any speech problems? ☐ Yes ☐ No

Do you generally breathe through your mouth? ☐ Yes ☐ No

If Yes, (circle one): While Awake/ While Asleep

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and they it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. 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 the office, use the services of one or more credit reporting services.

Signature: _____Date:_____