MEDICAL & DENTAL HISTORY

Have you ever seen an orthodontist before?___________ Who?__________________________

Was any treatment provided?____

Please "X" all that apply:

Tonsils/Adenoids Removed____
Periodontal Therapy___
Rheumatic Fever ___
Difficulty opening wide ___
High Stress ___
Frequent neck/back aches ___
Frequent earaches ___
Difficulty breathing through your nose___
Heart problems: ___ Please explain:____

Headaches___
Mouth breathing ___
Hep A, B, C ___
Epilepsy ___
Pregnant ___
Sinus Problems ___
Arthritis ___

Grinding/Clenching ___
Clicking/popping in jaw___
Trauma to head/face ___
Surgery to head/face ___
AIDS ___ Cancer___
Speech Problems ___
ADD/ADHD ___

Smoke of smokeless tobacco:_____ If yes, How many pack her day?______________________

Are you currently taking any medications? ______
Please list what you are currently taking: (including herbal or homeopathic)

____

Any other health problems:____

ALLERGIES:____

EMERGENCY INFORMATION

Name:_______________________________________ Relationship:______________________

Home Phone:____________________ Work:___________________Cell:__________________

INSURANCE INFORMATION

Insured Name:________________________________DOB:_________ SSN:_______________

Insurance Company:_______________________________________ Group #:______________

Do you have dual coverage: YES NO If yes, who:_________________________________

Insured Name:____ SSN:________________

Insurance Company:_______________________________________ Group #:______________

The information that I have given is correct to the best of my knowledge. I understand that it will be help in the strictest confidence, and it is my responsibility to inform you of any changes in the patient's health. I authorize the dental staff to perform the necessary dental services on the patient. I further authorize the release of any necessary information or records to my insurance company.

____ ____________________
Signature of Patient or Parent/Guardian *Date*