GreatBigSmiles
ORTHODONTICS

Patient Medical/Dental History

Patient Name _____Age (_____) Birthdate _____

Nickname/ likes to be called_____ School/ Employer:_____ Grade:____ Sex: M F

If patient is a minor, name of person(s) with patient at exam _____Relationship_____

Has Patient or family member been to our office before regarding orthodontics? Y N If yes, who?_____

Has Patient seen another Orthodontist ?_____ If yes, who? _____When?_____

How did you hear about our office? ☐ Internet ☐ Dentist ☐ School Event ☐ Friend or Family (who?) _____

Main concern for today's evaluation? _____

Emergency Contact Information:
Name of nearest relative not living with you:_____Relationship_____

Address_____ Contact Phone #_____

Family Physician_____

Is patient under the care of a Physician?_____ If Yes, for what?_____
List medication being taken_____ For what? _____
List allergies to any medications_____
Has the patient been diagnosed or treated for any of the following? (Circle all that apply)

Rheumatic Fever	Blood Disorders	Lung Disorders	Bone Disorders
Heart Condition	Anemia	Tuberculosis	Arthritis
Abnormal Blood Pressure	Hepatitis	Asthma	Diabetes
Heart Murmur	AIDS/HIV Pos.	Seizures	Speech concerns
Learning or attention challenges	Kidney conditions	Other _____	

Dentist_____

Oral Surgeon_____

Phone_____ Last Visit _____ Any dental work left to be done? Yes/No If Yes, What?_____

Does the patient require PRE-medication before dental procedures?	YES	NO	
Has the patient ever taken medication for their bones?	YES	NO	
Does the patient have a latex allergy? Nickel allergy?	YES	NO	
Does the patient have a persistent thumb or finger habit?	YES	NO	
Is the patient a mouth-breather (versus breathing primarily through the nose)?	YES	NO	
Does the patient have difficulty breathing through their nose?	YES	NO	
Does the patient have sleep apnea?	YES	NO	
Has the patient ever had their tonsils and/or adenoids removed?	YES	NO	
Does the patient vomit, gag, or faint easily?	YES	NO	
Does the patient experience frequent headaches or neck aches?	YES	NO	SOMETIMES
Does the patient grind or clench their teeth?	YES	NO	SOMETIMES
Has the patient experienced any pain, popping, or locking of the jaw?	YES	NO	SOMETIMES
Has the patient ever experienced trauma to their jaw or teeth?	YES	NO	WHEN ?_____
Has the patient been treated or recommended treatment for periodontal disease?	YES	NO	WHEN ?_____
GIRLS~ Has she started menstruation?	YES	NO	WHEN ?_____
BOYS~ Has his voice changed?	YES	NO	WHEN ?_____
Is Patient/Parent aware that appointments will infringe on work/school?	YES	NO	

I understand the information that I have provided 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 medical or dental status.

_____ _____
Signature Date

_____ _____
Doctor Signature Date