East Texas Orthodontics

ADULT PATIENT INFORMATION

TITLE ☐ Dr. ☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs.

NAME ______________________________ PREFERRED NAME ______________________

BIRTHDATE ______________________ AGE _________ GENDER ☐ MALE ☐ FEMALE

ADDRESS (home) ____# OF YEARS @ ADDRESSS ________

PHONE (home) ____________________ (work) ____________________ (cell) ____________________

EMAIL ______________________________ SSN ______________________________

EMPLOYER ________________________ # OF YEARS_________ OCCUPATION ____________________

DENTIST ____________________________________DATE OF LAST VISIT ____________________

HAS PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? ____________________

EMERGENCY CONTACT INFORMATION

NAME ______________________________ RELATIONSHIP______________________

ADDRESS (home) ____

PHONE (home) ____________________ (work) ____________________ (cell) ____________________

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? ____

WHOM MAY WE THANK FOR REFERRING YOU TO EAST TEXAS ORTHODONTICS?______________________________

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that is it our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME ____________________ **SIGNATURE** ______________________ **DATE** ________________

(OVER)

Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. ***For the following questions mark yes, no, or don't know/understand (dk/u).***

MEDICAL HISTORY

Now or in the past, have you had:

☐**yes** ☐**no** ☐**dk/u** Birth defects or hereditary problems?
☐**yes** ☐**no** ☐**dk/u** Bone fractures, or major injuries?
☐**yes** ☐**no** ☐**dk/u** Any injuries to face, head, neck?
☐**yes** ☐**no** ☐**dk/u** Arthritis or joint problems?
☐**yes** ☐**no** ☐**dk/u** Endocrine or thyroid problems?
☐**yes** ☐**no** ☐**dk/u** Diabetes or low sugar?
☐**yes** ☐**no** ☐**dk/u** Kidney problems?
☐**yes** ☐**no** ☐**dk/u** Cancer, tumor, radiation treatment or chemotherapy?
☐**yes** ☐**no** ☐**dk/u** Stomach ulcer, hyperacidity, acid reflux?
☐**yes** ☐**no** ☐**dk/u** Immune system problems?
☐**yes** ☐**no** ☐**dk/u** History of osteoporosis?
☐**yes** ☐**no** ☐**dk/u** Gonorrhea, syphilis, herpes, sexually transmitted diseases
☐**yes** ☐**no** ☐**dk/u** AIDS or HIV positive?
☐**yes** ☐**no** ☐**dk/u** Hepatitis, jaundice or other liver problem?
☐**yes** ☐**no** ☐**dk/u** Polio, mononucleosis, tuberculosis, pneumonia?
☐**yes** ☐**no** ☐**dk/u** Seizures, fainting spells, neurologic problem?
☐**yes** ☐**no** ☐**dk/u** Mental health disturbance or depression?
☐**yes** ☐**no** ☐**dk/u** Vision, hearing, or speech problems?
☐**yes** ☐**no** ☐**dk/u** History of eating disorder (anorexia, bulimia)?
☐**yes** ☐**no** ☐**dk/u** High or low blood pressure?
☐**yes** ☐**no** ☐**dk/u** Excessive bleeding or bruising, anemia?
☐**yes** ☐**no** ☐**dk/u** Chest pain, shortness of breath, tire easily, swollen ankles?
☐**yes** ☐**no** ☐**dk/u** Heart defects, heart murmur, rheumatic heart disease?
☐**yes** ☐**no** ☐**dk/u** Angina, arteriosclerosis, stroke or heart attack?
☐**yes** ☐**no** ☐**dk/u** Skin disorder (other than common acne)?
☐**yes** ☐**no** ☐**dk/u** Do you eat a well-balanced diet?
☐**yes** ☐**no** ☐**dk/u** Frequent headaches or migraines?
☐**yes** ☐**no** ☐**dk/u** Frequent ear infections, colds, throat infections?
☐**yes** ☐**no** ☐**dk/u** Asthma, sinus problems, hayfever?
☐**yes** ☐**no** ☐**dk/u** Tonsil or adenoid condition?
☐**yes** ☐**no** ☐**dk/u** Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:

☐**yes** ☐**no** ☐**dk/u** Local anesthetics (novocaine, lidocaine, xylocaine)
☐**yes** ☐**no** ☐**dk/u** Latex (gloves, balloons)
☐**yes** ☐**no** ☐**dk/u** Aspirin
☐**yes** ☐**no** ☐**dk/u** Ibuprofen (Motrin, Advil)
☐**yes** ☐**no** ☐**dk/u** Penicillin
☐**yes** ☐**no** ☐**dk/u** Other antibiotics
☐**yes** ☐**no** ☐**dk/u** Metals (jewelry, clothing snaps)
☐**yes** ☐**no** ☐**dk/u** Acrylics
☐**yes** ☐**no** ☐**dk/u** Plant pollens
☐**yes** ☐**no** ☐**dk/u** Animals
☐**yes** ☐**no** ☐**dk/u** Foods
☐**yes** ☐**no** ☐**dk/u** Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

☐**yes** ☐**no** ☐**dk/u** Permanent or extra (supernumerary) teeth removed?
☐**yes** ☐**no** ☐**dk/u** Supernumerary (extra) or congenitally missing teeth?
☐**yes** ☐**no** ☐**dk/u** Chipped or injured primary or permanent teeth?
☐**yes** ☐**no** ☐**dk/u** Any sensitive or sore teeth?
☐**yes** ☐**no** ☐**dk/u** Bleeding gums, bad taste or mouth odor?
☐**yes** ☐**no** ☐**dk/u** Jaw fractures, cysts, infections?
☐**yes** ☐**no** ☐**dk/u** Any teeth treated with root canals or pulpotomies?
☐**yes** ☐**no** ☐**dk/u** “Gum boils,” **f**requent canker sores or cold sores?
☐**yes** ☐**no** ☐**dk/u** History of speech problems or speech therapy?
☐**yes** ☐**no** ☐**dk/u** Difficulty breathing through nose?
☐**yes** ☐**no** ☐**dk/u** Food impaction between the teeth?
☐**yes** ☐**no** ☐**dk/u** Mouth breathing habit or snoring at night?
☐**yes** ☐**no** ☐**dk/u** History of speech problems?
☐**yes** ☐**no** ☐**dk/u** Frequent oral habits (sucking finger, chewing pen, etc.)?
☐**yes** ☐**no** ☐**dk/u** Teeth causing irritation to lip, cheek or gums?
☐**yes** ☐**no** ☐**dk/u** Abnormal swallowing (tongue thrust)?
☐**yes** ☐**no** ☐**dk/u** Tooth grinding or clenching?
☐**yes** ☐**no** ☐**dk/ u** Clicking, locking in jaw joints?
☐**yes** ☐**no** ☐**dk/u** Soreness in jaw muscles or face muscles?
☐**yes** ☐**no** ☐**dk/u** Ringing in ears, difficulty in chewing or opening jaw?
☐**yes** ☐**no** ☐**dk/u** Have you ever been treated for “TMJ” or “TMD” problems?
☐**yes** ☐**no** ☐**dk/u** Any broken or missing fillings?
☐**yes** ☐**no** ☐**dk/u** Any serious trouble associate with previous dental treatment?
☐**yes** ☐**no** ☐**dk/ u** Have you ever been diagnosed with gum disease or pyorrhea?
☐**yes** ☐**no** ☐**dk/u** Have you ever had an orthodontic consultation or treatment before now?

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PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____

How often do you floss?_____

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature ____

Date_____________________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature ____

Date_____________________________

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MEDICAL HISTORY UPDATES OR CHANGES

Changes _____
Patient Signature ____
Date_______________________________
Dental Staff Signature ____
Date_______________________________

Changes _____
Patient Signature ____
Date_______________________________
Dental Staff Signature ____

Date_______________________________

Changes _____
Patient Signature ____
Date_______________________________
Dental Staff Signature ____

Date_______________________________

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