# WELCOME TO OUR OFFICE

COMPUTER NO. | LAST | PATIENT NAME | MODEL NO. | EXAM DATE

| PATIENT LIKES TO BE CALLED | D.O.B. | SEX | PT. HOME PHONE | PT. WORK PHONE |
|---|---|---|---|---|

PT. ADDRESS
STREET | CITY | PROV. | POST. CODE

IF STUDENT, SCHOOL NAME | HOBBIES & INTERESTS

(MOTHER) (FATHER)
IF PATIENT IS A MINOR - PARENT'S/GUARDIAN NAME | WHO REFERRED PT.

FAMILY DENTIST | ADDRESS

PHYSICIAN | ADDRESS

| PERSON(S) RESPONSIBLE RESPONSIBLE FOR ACCOUNT | PERSON(S) RESPONSIBLE RESPONSIBLE FOR ACCOUNT |
|---|---|
| (LAST) (FIRST) (MIDDLE) | (LAST) (FIRST) (MIDDLE) |
| STREET CITY PROV. POST. CODE | STREET CITY PROV. POST. CODE |
| HOME PHONE WORK PHONE BIRTHDATE RELATIONSHIP TO PT. | HOME PHONE WORK PHONE BIRTHDATE RELATIONSHIP TO PT. |
| EMPLOYERS NAME | EMPLOYERS NAME |
| STREET CITY PROV. POST. CODE | STREET CITY PROV. POST. CODE |
| ORTHODONTIC INS. CO. NAME | ORTHODONTIC INS. CO. NAME |

E-MAIL:

## MEDICAL HISTORY

| | YES | NO | |
|---|---|---|---|
| Is the patient in good health? | ☐ | ☐ | Reason ____ |
| Any major or unusual illnesses? | ☐ | ☐ | Explain ____ |
| Currently under physician's care? | ☐ | ☐ | Reason ____ |
| Currently taking medication | ☐ | ☐ | List ____ |
| Allergies | ☐ | ☐ | List ____ |
| Drug sensitivity | ☐ | ☐ | List ____ |
| Have you ever been hospitalized? | ☐ | ☐ | If so, for what? ____ |

**Please check (✔) if patient has or has had any of the following:**

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Anaemia | ☐ | ☐ | Endocrine problems | ☐ | ☐ | Tonsilitis | ☐ | ☐ | Heart problems | ☐ | ☐ |
| Blood disease | ☐ | ☐ | Bone disorders | ☐ | ☐ | Adenitis | ☐ | ☐ | Congenital heart defects | ☐ | ☐ |
| Prolonged bleeding | ☐ | ☐ | Epilepsy | ☐ | ☐ | Tonsils removed: Age: | ☐ | ☐ | Heart murmur | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Herpes | ☐ | ☐ | Adenoids removed: Age: | ☐ | ☐ | Prosthetic joints | ☐ | ☐ |
| Jaundice | ☐ | ☐ | Rheumatic fever | ☐ | ☐ | Asthma | ☐ | ☐ | Joint pain | ☐ | ☐ |
| Heart disease | ☐ | ☐ | Do you require prophylactic medication? | ☐ | ☐ | Mouth breathing: While awake? | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | Do you have AIDS or are you HIV positive? | ☐ | ☐ | While asleep? | ☐ | ☐ | Frequent headaches | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Frequent colds or flu | ☐ | ☐ | | | | | | |

**Growth information for patients under 16 years of age**

Father's height ____ Mother's height ____ Are you adopted? Yes ☐ No ☐

Patient resembles ☐ Father ☐ Mother ☐ Neither Parent

Girls: Has she started menstruation? ☐ Yes ☐ No When? ____

Boys: Has his voice changed? ☐ Yes ☐ No When? ____

Name and ages of patient's brothers and sisters ____

## DENTAL HISTORY

| | YES | NO | |
|---|---|---|---|
| Has the patient had trauma to the teeth? | ☐ | ☐ | Reason ____ |
| Has the patient had any severe head or face injuries? | ☐ | ☐ | Explain ____ |
| Has the patient had a history of thumb sucking or finger sucking? | ☐ | ☐ | Stopped? ____ |
| Does the patient play any musical (wind) instruments? | ☐ | ☐ | What? ____ |
| Has the patient consulted an orthodontist previously? | ☐ | ☐ | ____ |
| Has the patient had any previous orthodontic treatment? | ☐ | ☐ | ____ |
| Has the patient ever had a bad dental experience? | ☐ | ☐ | Explain ____ |
| Is the patient fearful of having dental work done? | ☐ | ☐ | ____ |

**Please check (✔) if there is a history of:**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Clenching teeth | ☐ | ☐ | Headaches (more than normal) | ☐ | ☐ | Jaw joint popping | ☐ | ☐ |
| Grinding teeth | ☐ | ☐ | Jaw joint soreness | ☐ | ☐ | Ringing in the ears | ☐ | ☐ |
| Muscular soreness around the head and neck | ☐ | ☐ | Jaw joint clicking | ☐ | ☐ | Jaw joint locking | ☐ | ☐ ☐ Open ☐ Closed |

Is there any other information that may be helpful? ____

Why are you seeking orthodontic consultation? ____

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history records, I will inform this practice. I also give my authorization for an orthodontic exam to be performed.

THANK YOU! Signed ____