PATIENT INFORMATION

Date__________________

Patient's name____
Last First

Birthdate______________

Parent(s) name ____
Last First

Mailing Address____
Street City Postal Code

Cell Phone_____________________ Email Address ____

2nd Cell phone________________________ Work phone ____

Patient's Dentist Name____ Dentist Phone ______________________________

Date of last full dental cleaning and checkup____

Patient's Family Physician Name____

Whom may we thank for referring you to our office? ____

MEDICAL HISTORY

Please circle Yes or No (If **Yes**, please fill in details)

Yes No Are you presently or within the last year been under the care of a physician? _________________________

Yes No Are you taking any medication? ____

Yes No Are you allergic to any medication? ____

Yes No Do you have a history of serious illness or hospitalization? _______________________________________

Yes No Have you had any operations? ____

Yes No Have you ever smoked or chewed tobacco? ____

Yes No Are you in good health? ____

Female Patients only:
Yes No Are you pregnant? ____
Yes No Has menstruation started? ____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions or allergies we have not discussed that you feel we should be aware of? _______________
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DENTAL HISTORY

Yes No Have there been any injuries to face, mouth, or teeth? ____

Yes No Have any teeth been removed (baby teeth or permanent?) ____

Yes No Have you been informed of any missing or extra permanent teeth?__________________________________

Yes No Has the patient ever sucked a thumb or finger? Until what age? ____________________________________

Yes No Does the patient have any speech problems? ____

Yes No Is the patient a mouth breather? ____

Yes No Does the patient have frequent colds and/or ear infections? _______________________________________

Yes No Are you aware of either excessive grinding, jaw joint noises or jaw pain? _____________________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _______________________

Yes No Have you ever seen an orthodontist? If yes, who and when?_______________________________________

Yes No Are you aware that some appointments will be during school/work hours? ____________________________

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used anonymously for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my/my child's medical or dental history. In addition, I authorize Dr. Paradisgarten to perform a complete orthodontic evaluation.

Signature: ____ Date: ____________________