

MEDICAL AND DENTAL INFORMATION

PRELIMINARY INFORMATION

Today's Date _____

Patient's Name _____ Last _____ First _____ Middle _____ Nickname _____ Sex _____

Date of Birth _____/_____/_____. Age in Years _____ School _____ Grade _____

Home Address _____ Street No. _____ Street Name _____ Phone _____

City _____ State _____ Zip _____

Previous Address _____ Street No. _____ Street Name _____ City and Zip _____

Father's Name _____ Last _____ First _____ Middle _____ Social Sec. No. _____ Age _____

Father's Occupation _____ Business Phone No. _____

Business Address _____ Street No. _____ Street Name _____ City _____ State _____ Zip _____

Mother's Name _____ Last _____ First _____ Middle _____ Social Sec. No. _____ Age _____

Mother's Occupation _____ Business Phone No. _____

Business Address _____ Street No. _____ Street Name _____ City _____ State _____ Zip _____

Person Responsible for Account If Now Divorced or Separated _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Pol. # _____

Insurance Co. _____ Group # _____

Insured's Employer _____

MEDICAL HISTORY

The patient's Medical and Dental History information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Is patient in good health? Yes No
2. Has there been any change in patient's general health within the past year? Yes No
3. Patient's last physical examination was on _____
4. Is patient now under the care of a physician? Yes No
If so, what is the condition being treated? _____
5. The name and address of patient's physician(s) is _____

6. Is patient taking any medicine(s) including non-prescription medicine? Yes No
If so, what medicine(s) are being taken? _____
7. Has patient had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
If so, what was the illness or problem? _____
8. Does patient have tendency to sore throats? If yes, how often? _____ Yes No
Does patient have tendency to ear aches? If yes, how often? _____ Yes No
Have Tonsils and Adenoids been removed? If yes, when? _____ Yes No
Does patient have tendency to colds? If yes, how often? _____ Yes No
9. Has patient had any injuries to the face, head or teeth? If yes, please give complete details including date(s) of occurrence, nature of injury and who treated: _____ Yes No

10. Does patient have or has patient had any of the following diseases or problems?
 - a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? Yes No
 - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes No
 1. Pain in chest upon exertion? Yes No
 2. Ever short of breath after mild exercise or when lying down? Yes No
 3. Do ankles swell? Yes No
 4. Have inborn heart defects? Yes No
 5. Have a cardiac pacemaker? Yes No
 6. Ever had heart surgery? Yes No
 - c. Allergy Yes No
 - d. Sinus trouble Yes No
 - e. Asthma or hay fever Yes No
 - f. Fainting spells or seizures, dizziness Yes No

- | | | | |
|-----|---|-----|----|
| g. | Persistent diarrhea or recent weight loss | Yes | No |
| h. | Diabetes | Yes | No |
| i. | Hepatitis, jaundice or liver disease | Yes | No |
| j. | AIDS or HIV infection | Yes | No |
| k. | Thyroid problems | Yes | No |
| l. | Respiratory problems, emphysema, bronchitis, etc. | Yes | No |
| m. | Arthritis or painful swollen joints | Yes | No |
| n. | Stomach ulcer or hyperacidity | Yes | No |
| o. | Kidney trouble | Yes | No |
| p. | Tuberculosis | Yes | No |
| q. | Persistent cough or cough that produces blood | Yes | No |
| r. | Persistent swollen glands in neck | Yes | No |
| s. | Low blood pressure | Yes | No |
| t. | Sexually transmitted disease | Yes | No |
| u. | Epilepsy or other neurological disease | Yes | No |
| v. | Problems with mental health | Yes | No |
| w. | Cancer | Yes | No |
| x. | Problems with immune system | Yes | No |
| y. | Alcoholism or drug dependency or addiction | Yes | No |
| z. | Scarlet Fever | Yes | No |
| aa. | Chemotherapy | Yes | No |
| bb. | Radiation Therapy | Yes | No |
| cc. | Cortisone Therapy | Yes | No |
| dd. | Cosmetic Surgery | Yes | No |
| ee. | Diabetes | Yes | No |
| ff. | Rheumatism | Yes | No |
| gg. | Epilepsy | Yes | No |
| hh. | Chicken Pox | Yes | No |
| ii. | Fever Blisters | Yes | No |
| jj. | Glaucoma | Yes | No |
| kk. | Measles | Yes | No |
| ll. | Mumps | Yes | No |
| mm. | Nervousness/anxiety | Yes | No |
| nn. | Psychological treatment | Yes | No |
| oo. | Psychiatric treatment | Yes | No |
| pp. | Ulcers | Yes | No |
| 11. | Have you had abnormal bleeding? | Yes | No |
| a. | Have you ever required a blood transfusion | Yes | No |
| 12. | Do you have any blood disorder such as anemia, hemophilia, leukemia, sickle cell disease? | Yes | No |
| a. | Do you bruise easily | Yes | No |
| 13. | Have you ever had any treatment for a tumor or growth? | Yes | No |
| 14. | Are you allergic or have you had a reaction to: | | |
| a. | Local anesthetics | Yes | No |
| b. | Penicillin or other antibiotics | Yes | No |
| c. | Sulfa drugs | Yes | No |
| d. | Barbiturates, sedatives, or sleeping pills | Yes | No |
| e. | Aspirin | Yes | No |
| f. | Iodine | Yes | No |
| g. | Codeine or other narcotics | Yes | No |
| h. | Other _____ | | |
| 15. | Have you had any problems associated with any previous dental treatment? | Yes | No |
| | If so, explain _____ | | |
| 16. | Do you have any disease, condition, or problem not listed above that you think I should know about? | Yes | No |
| | If so, explain _____ | | |
| 17. | Are you wearing contact lenses? | Yes | No |
| 18. | Are you wearing removable dental appliances? | Yes | No |

Women

19.	Are you pregnant?	Yes	No
20.	Do you have any problems associated with your menstrual period?	Yes	No
21.	Are you nursing?	Yes	No
22.	Are you taking birth control pills?	Yes	No
23.	Is there any other medical (health) information you would like us to know? If yes, please explain	Yes	No

The medical information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in my health and of recent visits to my physician at my next visit. In addition, I authorize Dr. Wirtz to perform a complete orthodontic examination.

Date

Signature

DENTAL HISTORY
GENERAL DENTAL INFORMATION

1. When was your last dental visit? _____
2. How frequently do you visit your dentist? _____
3. The name and address of my dentist is: _____

4. When was your last full mouth or panoramic series of x-rays? _____
5. Are you having any dental problems now? Yes No
If yes, please specify _____

6. I would describe my temperament as: _____
7. My hobbies or sports interests are: _____
8. Do you anticipate a move or transfer in the near future? Yes No
If yes, please explain _____
9. Are you pleased with the way your teeth look? Yes No
If no, please explain _____
10. Are your teeth discolored? Yes No
11. Are you unhappy with your smile? Yes No
12. Have you ever been in an auto accident? Yes No
If yes, please explain _____

13. Have you ever had an injury to your head, face, or neck? Yes No
If yes, please explain _____
14. Have you ever had teeth removed? Yes No
15. Have your wisdom teeth been removed? Yes No
If yes, when and by whom? _____
16. Are you a mouth breather? Yes No
17. Have you ever had a finger or thumb habit? Yes No
18. Are your teeth sensitive to cold, hot or foods? Yes No
19. Would you mind wearing braces? Yes No
If yes, please explain _____
20. What is your main reason for seeking orthodontic treatment? _____

21. Please specify any other reasons you have for seeking orthodontic treatment _____

ORTHODONTIC INFORMATION

1. Have you ever had orthodontic treatment (braces)? Yes No
If yes, when and by whom _____
2. Have you ever had an orthodontic examination, evaluation, conference or consultation? Yes No
If yes, when and by whom _____
3. Have you ever had orthodontic records, such as x-rays, study models or photographs? Yes No
If yes, when and by whom _____
4. Do you feel your teeth can be straighter? Yes No
5. Do you feel your occlusion (bite) needs to be improved? Yes No
6. Have you ever been told to see an orthodontist? Yes No
If yes, when and by whom _____

PERIODONTAL (GUM) INFORMATION

1. Do you feel your gingiva (gums) are healthy? Yes No
If no, please explain _____
2. Do your gums bleed when brushing? Yes No
3. Have your gums ever bled when brushing? Yes No
4. Do you regularly use dental floss or tape? Yes No
If yes, since when? _____
5. Have you ever been told that you have gum disease? Yes No
If yes, when and by whom? _____
6. Have you ever been advised to have periodontal (gum) treatment? Yes No
7. Have you ever had a periodontal examination? Yes No
If yes, when and by whom? _____
8. Have you ever had periodontal (gum) treatment? Yes No
If yes, when and by whom _____
9. Will you follow instructions regarding good oral hygiene? Yes No
10. Have you ever been told or have you ever noticed that your gums are receding? Yes No
If yes, please explain _____

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

- | | | |
|--|-----|----|
| 1. Do you feel patient's jaw joint is healthy? | Yes | No |
| If no, please explain _____ | | |
| 2. Does patient's jaw joint(s) click, crack, pop, grate or make any other sound(s)? | Yes | No |
| If yes, please explain _____ | | |
| 3. Has patient's jaw joint(s) ever made any of the above or other sounds? | Yes | No |
| If yes, please explain _____ | | |
| 4. Does patient grind teeth? | Yes | No |
| 5. Does patient clench teeth? | Yes | No |
| 6. If patient is experiencing stress, does patient grind teeth? | Yes | No |
| 7. Does patient ever have or has patient ever had jaw soreness, jaw pain, muscle soreness (jaw area) neck soreness? | Yes | No |
| If yes, please explain _____ | | |
| 8. Does patient now or has patient previously experienced aches or pains in the following areas: | | |
| a. Front of the head | Yes | No |
| b. Over the eyes | Yes | No |
| c. Sinus area | Yes | No |
| d. Temple area | Yes | No |
| e. Cheeks or side of the face | Yes | No |
| f. Top of the head | Yes | No |
| g. Back of the head | Yes | No |
| h. Back of the neck | Yes | No |
| i. Side of the neck | Yes | No |
| j. Tongue or under the tongue | Yes | No |
| k. Front of the neck | Yes | No |
| l. Shoulders | Yes | No |
| m. Upper back | Yes | No |
| n. Lower back | Yes | No |
| o. Other pain, please describe | Yes | No |
| For the above problems, what circumstances seem to cause the problem(s), make it worse or make it better? _____ | | |
| a) _____ | | |
| b) _____ | | |
| c) _____ | | |
| 9. Does patient now or has patient previously experienced ear aches, ear pain, stuffiness in his or her ear(s), reduced hearing or loss of hearing?..... | Yes | No |
| If yes, please explain _____ | | |
| 10. Has patient's jaw ever "locked" open or closed? | Yes | No |
| If yes, please explain _____ | | |
| 11. Has patient ever been told that patient has a TMJ or "Jaw Joint" problem? | Yes | No |
| If yes, when and by whom _____ | | |
| 12. Has patient ever been advised to have treatment for a TMJ or "Jaw Joint" problem? | Yes | No |
| If yes, when and by whom _____ | | |
| 13. Has patient ever had treatment for a TMJ "Jaw Joint" problem? | Yes | No |
| If yes, when and by whom _____ | | |
| 14. Has patient ever worn a splint or nightguard appliance for any reason? | Yes | No |
| If yes, please explain _____ | | |
| 15. Has patient ever had a TMJ or "Jaw Joint" examination? | Yes | No |
| If yes, when and by whom _____ | | |
| 16. Has patient ever been told that they have jaw arthritis? | Yes | No |
| If yes, when and by whom _____ | | |

The dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in patient's dental health and of recent visits to patient's dentist at the next visit.

_____ Date

_____ Signature

FOR OFFICE USE ONLY

Comments concerning medical history: _____

Significant findings: _____

Orthodontic management considerations: _____

_____ (Date)

_____ Examining Dentist

Medical/Dental history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
