ORTHODONTICS
LIMITED, PC

Medical History Form – Patient Information

Date _____

PATIENT

Patient Name _____ Home Phone (_____) _____

Address _____ Cell Phone (_____) _____

City/State/Zip _____ Email _____

Date of Birth ____/____/____ Sex M F Height_____ Weight_____ Single_____ Married _____

Referred by _____ Family Dentist _____ Last Visit _____

If you are completing this form for another person, what is your relationship to that person? _____

Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

PARENT/GUARDIAN

Custodial Parent Name _____ Email _____

Address (if different) _____ City/State/Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Custodial Parent Name _____ Email _____

Address (if different) _____ City/State/Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

FINANCIAL RESPONSIBILITY

Who will be financially responsible for this account? _____

Address (if different) _____ City/State/Zip _____

Home Phone (____)_____ Cell Phone (____)_____ Email_____

Social Security # _____ D.O.B. _____

MEDICAL HISTORY

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Yes	No	
☐	☐	Are you in good health?
☐	☐	Has there been any change in your general health within the past year?
☐	☐	My last physical examination was on _____
☐	☐	Are you now under the care of a physician?

If so, what is the condition being treated? _____

The name and address of my physician(s) is _____

_____

Do you have or have you had any of the following diseases or problems?

Yes	No	
☐	☐	Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease
☐	☐	Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
☐	☐	Do you have chest pain upon exertion
☐	☐	Are you ever short of breath after mild exercise or when lying down?
☐	☐	Do your ankles swell?
☐	☐	Do you have inborn heart defects?
☐	☐	Do you have a cardiac pacemaker?
☐	☐	Allergy
☐	☐	Sinus trouble
☐	☐	Asthma or hay fever (Please circle)
☐	☐	Fainting spells or seizures
☐	☐	Persistent diarrhea or recent weight loss
☐	☐	Diabetes
☐	☐	Hepatitis, jaundice or liver disease
☐	☐	AIDS or HIV infection
☐	☐	Thyroid problems
☐	☐	Respiratory problems, emphysema, bronchitis, etc.
☐	☐	Arthritis or painful swollen joints
☐	☐	Stomach ulcer or hyperacidity
☐	☐	Kidney trouble
☐	☐	Tuberculosis
☐	☐	Persistent cough or cough that produces blood
☐	☐	Persistent swollen glands in neck
☐	☐	Low blood pressure
☐	☐	Sexually transmitted disease
☐	☐	Epilepsy or other neurological disease
☐	☐	Problems with mental health
☐	☐	Cancer
☐	☐	Problems of the immune system
☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years?

If so, what was the illness or problem? _____

Yes	No	
☐	☐	Are you taking any medicine(s) including non-prescription medicine?

If so, what medicine(s) are you taking? _____

Yes No

- ☐ ☐ Have you had abnormal bleeding?
- ☐ ☐ Have you ever required a blood transfusion?
- ☐ ☐ Do you have any blood disorder such as anemia?
- ☐ ☐ Have you ever had any treatment for a tumor or growth?

Are you allergic or have you had a reaction to:

- ☐ ☐ Local anesthetics
- ☐ ☐ Penicillin or other antibiotics
- ☐ ☐ Sulfa drugs
- ☐ ☐ Barbiturates, sedatives, or sleeping pills
- ☐ ☐ Aspirin
- ☐ ☐ Iodine
- ☐ ☐ Codeine or other narcotics
- ☐ ☐ Other _____
- ☐ ☐ Have you had any serious trouble associated with any previous dental treatment?

If so, explain _____

_____

- ☐ ☐ Do you have any disease, condition, or problem not listed above that you think I should know about?

If so, explain _____

_____

- ☐ ☐ Are you wearing contact lenses?
- ☐ ☐ Are you wearing removable dental appliances?
- ☐ ☐ Do you have a latex allergy?

Women

- ☐ ☐ If child, has menstruation begun?
- ☐ ☐ Are you pregnant?
- ☐ ☐ Are you nursing?
- ☐ ☐ Are you taking birth control pills?

Chief Dental Complaint _____

_____

_____

_____

_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

X _____

Signature of Patient / Parent

DENTAL INSURANCE

Primary policy holder's full name _____ Date of Birth _____

Contact Phone (_____) _____ Email Address_____

Social Security # _____ Relationship to Patient _____

Street Address (if not listed above) _____ City/State/Zip_____

Employer _____ Address _____

Insurance Co. _____ Group #_____ ID #_____

Does this policy have orthodontic benefits? Yes____ No____ Don't Know____

Secondary policy holder's full name _____ Date of Birth _____

Contact Phone (_____) _____ Email Address_____

Social Security # _____ Relationship to Patient _____

Street Address (if not listed above) _____ City/State/Zip_____

Employer _____ Address _____

Insurance Co. _____ Group #_____ ID #_____

Does this policy have orthodontic benefits? Yes____ No____ Don't Know____