Medical History

Patient's physician(s) _____ Date last seen _____

Address _____ Phone _____

1. Please circle you PRESENT HEALTH: excellent good fair poor
2. Has your health CHANGED in the last year? . . . . . Yes No
3. Have you been HOSPITALIZED in the last 5 years? . . . . . Yes No
4. Has a doctor TREATED or EXAMINED you for any condition in the last 3 years? . . . . Yes No
5. Are you ALLERGIC to any drugs or other substances? . . . . . Yes No
6. Are you required to restrict your work or activities? . . . . . Yes No
7. Is your diet restricted or specially prescribed? . . . . . Yes No
8. Are you taking ANY MEDICATIONS regularly (even aspirin or antacids)? . . . . . Yes No

If "Yes", please list them with dosages: _____

_____

_____

PLEASE CIRCLE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM.

1. Heart trouble or murmur	Yes	No	17. Bronchitis	Yes	No	34. Sinus trouble	Yes	No
2. Rheumatic fever	Yes	No	18. Frequent colds/			35. Artificial joints or valves	Yes	No
3. Heart surgery	Yes	No	sore throat	Yes	No	36. Venereal disease	Yes	No
4. Heart attack	Yes	No	19. Emphysema	Yes	No	37. Thyroid/parathyroid		
5. High blood pressure	Yes	No	20. Birth Defects	Yes	No	disorders	Yes	No
6. Low blood pressure	Yes	No	21. Scarlet fever	Yes	No	38. Cancer or tumors	Yes	No
7. Chest pains	Yes	No	22. Hives/rash	Yes	No	39. Tuberculosis	Yes	No
8. Stroke	Yes	No	23. Recurrent illness	Yes	No	40. Speech impairment or		
9. Immune system			24. Diabetes	Yes	No	therapy	Yes	No
problems, AIDS	Yes	No	25. Kidney disease	Yes	No	41. Hearing problem	Yes	No
10. Blood transfusion	Yes	No	26. Liver disease	Yes	No	42. Emotional or		
11. Excessive or			27. Epilepsy/seizures	Yes	No	nervous problems	Yes	No
prolonged bleeding	Yes	No	28. Fainting/dizzy spells	Yes	No	43. Frequent headaches	Yes	No
12. Blood disorder	Yes	No	29. Ulcers	Yes	No	44. Smoker	Yes	No
13. Shortness of breath	Yes	No	30. Arthritis	Yes	No	45. Nervous/anxious	Yes	No
14. Persistent cough	Yes	No	31. Glaucoma	Yes	No	46. Recent unintentional		
15. Asthma/hay fever	Yes	No	32. Allergies	Yes	No	weight changes	Yes	No
16. Lung disease	Yes	No	33. Ear pains or infections	Yes	No	47. Psychiatric care	Yes	No
IF FEMALE, ARE YOU:								
Pregnant/Nursing	Yes	No	On Birth Control Pills	Yes	No			

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

_____

COMMENTS: _____

_____

_____

1. _____ Date _____
Signature of Parent or Guardian

2. _____ Date _____
Signature of Parent or Guardian

3. _____ Date _____
Signature of Parent or Guardian

4. _____ Date _____
Signature of Parent or Guardian

5. _____ Date _____
Signature of Parent or Guardian

6. _____ Date _____
Signature of Parent or Guardian

Adult

Northern Dental Specialists

DATE _____

PATIENTS NAME: _____ Prefer to be called: _____
Age: _____ Birthdate: _____ SSN: _____
Address: _____ City & Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Occupation: _____ Employer: _____
Address: _____ Phone: _____
Spouses Name: _____
Employer: _____ Occupation: _____ SSN: _____
Cell Phone: _____ Work Phone: _____
Hobbies/Interests: _____
Children and ages: _____
Other family members treated here: _____

Do you anticipate a move or transfer in the next 6-12 months? . . . . . Yes No
Does the patient have orthodontic insurance? . . . . . Yes No

Insurance Company: _____ SSN/ID number: _____
Name of Insured: _____ DOB: _____ Insurance Phone: _____

Whom may we thank for referring you to us? _____
How have you heard about our office (check all that apply)?
___ Friend/Family (Name(s) _____)
___ Your Dentist ___ Charity Event (Event name: _____)
___ Advertisement ___ Other _____

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____
Address: _____ Phone: _____

Have you had any of the following?
Previous orthodontic exam or treatment . . Yes No
Extractions (teeth removed)?. . . . . Yes No
Periodontal (gum) therapy? . . . . . Yes No
Endodontic (root canal) therapy? . . . . . Yes No
TMJ (jaw joint) problems or therapy? . . . . Yes No
Frequent toothaches or sensitive teeth? . . . Yes No

Are you aware of any of the following problems?
Clicking, popping or grating noise in your jaw joints? . . . Yes No
If yes, is there discomfort with it? . . . . . Yes No
Clenching or grinding of your teeth? . . . . . Yes No
Sores, lumps or irritated areas in your mouth? . . . . . Yes No
Food catching or collecting between your teeth? . . . . . Yes No
Numbness or pain in your mouth, jaw joints, or face? . . . Yes No

History of mouth breathing, finger or thumb sucking, nail biting? . . . . . Yes No
History of injury to face, head or teeth? . . . . . Yes No
Have tonsils and adenoids been removed? _____ Date: _____
Would you mind wearing "braces" if necessary? . . . . . Yes No

Describe the orthodontic problem in your own words (what are YOUR main concerns?) _____
_____
Who noticed the problem? Patient _____ Dentist _____
Any additional comments, questions, or suggestions: _____
_____
_____