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

Child

Northern Dental Specialists

DATE _____

PATIENTS NAME: _____ LIKES TO BE CALLED: _____
Age: _____ Birthdate: _____ Is Patient Adopted: _____
Address: _____ City & Zip: _____
Home Phone: _____ Email: _____
Patient's School: _____ Grade: _____
Hobbies/Interests: _____
Siblings and ages: _____
Other family members treated here: _____
Father's Name: _____ SSN: _____
Employer: _____ Occupation: _____
Cell Phone: _____ Work Phone: _____
Mother's Name: _____ SSN: _____
Employer: _____ Occupation: _____
Cell Phone: _____ Work Phone: _____
Person Financially Responsible for Account: _____
Father/Mother address if different from patient: _____

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
Endodonitc (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: _____
Has patient reached puberty (girls-menstruation; boys-voice change)?. . . . . Yes No
Would patient 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 _____ Parent _____ Dentist _____
Any additional comments, questions, or suggestions: _____