

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you Pregnant/Trying to get pregnant? Nursing?
 Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental History Form Orthodontics
McCalla Orthodontics and Pediatric Dentistry

- Yes No dk/u Started teething very early or late?
 Yes No dk/u Primary (baby) teeth removed that were not loose?
 Yes No dk/u Any missing permanent teeth?
 Yes No dk/u Any extra permanent teeth?
 Yes No dk/u Permanent or "extra" (supernumerary) teeth removed?
 Yes No dk/u Supernumerary (extra) or congenitally missing teeth?
 Yes No dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
 Yes No dk/u Teeth sensitive to hot or cold; teeth throb or ache?
 Yes No dk/u Jaw fractures, cysts, mouth infections?
 Yes No dk/u "Dead Teeth", root canals treated?
 Yes No dk/u Bleeding gums, bad taste, mouth odor?
 Yes No dk/u Periodontal "Gum Problems"?
 Yes No dk/u Food impaction between teeth?
 Yes No dk/u "Gum Boils", frequent canker sores, cold sores?
 Yes No dk/u Is child taking any forms of fluoride?
 Yes No dk/u Thumb, finger, sucking habit? Until?
 Yes No dk/u Abnormal swallowing habit (tongue thrusting)?
 Yes No dk/u History of speech problems?
 Yes No dk/u Mouth breathing habit, snoring, difficulty in breathing?
 Yes No dk/u Tooth grinding, jaw clenching, clicking, locking?
 Yes No dk/u Any pain in jaw or ringing in ears?
 Yes No dk/u Does the patient experience pain or soreness in the muscles of the face, or around the ears?
 Yes No dk/u Difficulty encountered in chewing or jaw opening?
 Yes No dk/u Aware of loose, broken or missing restorations (fillings)?
 Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?
 Yes No dk/u Concerned about spaced, crooked, protruding teeth?
 Yes No dk/u Aware or concerned about under or over developed jaw?
 Yes No dk/u Any relative with similar tooth or jaw relationships?
 Yes No dk/u Any wisdom tooth problems?
 Yes No dk/u Has patient had any serious trouble associated with any previous dental treatment?
 Yes No dk/u Has patient recently been under another dentist's care?
 Specialist _____ Other _____
 Yes No dk/u Has patient ever had periodontal (gum) treatment?
 Yes No dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
 Yes No dk/u Has patient ever had a prior orthodontic examination or treatment?
 Yes No dk/u Does patient visit dentist regularly? Date of last visit? _____

How often does patient brush? _____ Floss? _____

Approximately how much has patient grown in last year? _____

Onset of puberty? _____

Adolescent females: Has menstruation begun? _____ Date (M/Y) _____

List any other serious illnesses: _____

List any allergies: _____

List drugs or medications being taken now: _____

Is patient presently under physician's care? Yes No

Name of physician: _____

Patient's attitude toward orthodontic treatment: (Circle one)
 Very motivated Will cooperate if needed Not motivated

What is your main concern with your son/daughters teeth? _____

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for display at scientific meetings, presentations, and publications of a scientific nature or for study purposes to further the area and science of orthodontics.

 Signature of Patient or of Parent or Guardian if Patient is a minor

Date _____

Confidential Responsible Party Information

A B C

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ Cell # _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Insurance Information

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

**AUTHORIZATION TO BE SEEN WITH OUT
PARENT OR LEGAL GUARDIAN**

I, _____ the person legally
responsible for _____

(patient name), allow Dr. Sanchez to provide any necessary treatment to _____

(patient name) should he/she attend their dental appointment with anyone other than the
parent/legal guardian. Below is a list of those who can come with patient:

1) Name: _____

Relationship: _____

Phone Number: _____

2) Name: _____

Relationship: _____

Phone Number: _____

3) Name: _____

Relationship: _____

Phone Number: _____

Responsible Party Name (Print) _____

Signature _____

Date _____