

MEDICAL HISTORY

Physician _____

Date of Last Visit _____

Address _____

Phone _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have you seen a physician in the last 12 months? Why? _____

Please circle Yes or No for any medical condition that you have had or currently have:

- Yes No Abnormal bleeding/Hemophilia
- Yes No Anemia
- Yes No Arthritis
- Yes No Asthma or Hayfever
- Yes No Bone Disorders
- Yes No Congenital Heart Defect
- Yes No Diabetes
- Yes No Dizziness
- Yes No Epilepsy
- Yes No Gastrointestinal Disorders
- Yes No Heart Murmur
- Yes No Heart Problems
- Yes No Hepatitis/Liver Problems
- Yes No Herpes
- Yes No High Blood Pressure
- Yes No HIV/Aids
- Yes No Kidney Problems
- Yes No Nervous Disorders
- Yes No Pneumonia
- Yes No Prolonged Bleeding
- Yes No Radiation/Chemotherapy
- Yes No Rheumatic Fever
- Yes No Tuberculosis
- Yes No Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____

Date of last visit _____

Address _____

Phone _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started? _____

There are some appointments that will need to be completed during school/work hours.

Please list some hobbies or interests _____

BENEFITS of ORTHODONTIC TREATMENT

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Wells to perform a complete orthodontic evaluation.

Signature: _____ Date: _____