inLine orthodontics

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# MEDICAL HISTORY QUESTIONNAIRE

## PATIENT INFORMATION

Date _____

Patient's Name _____
First Middle Last Pref. Name

Home Address _____
Street City State Zip

Home Phone _____ Birthdate _____

Email _____ Facebook name(optional) _____

Friends or relative in treatment with us _____

Name and age of siblings _____

## RESPONSIBLE PARTY INFORMATION

Parent's Name _____
First Middle Last

Home Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Email Address _____ Employer _____

Spouse's Name _____
First Middle Last

Social Security # _____ Birthdate _____ Relationship to Patient _____

Email Address _____ Employer _____

## DENTAL INFORMATION

Family Dentist _____

Address _____
Street City State Zip

Date of last dental checkup _____

What are your main concerns about your teeth? _____

Whom may we thank for referring you? _____

## DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Employer _____

Insurance Company _____ Insured's ID # _____ Group No. _____

Insurance Co. Address _____
Street City State Zip

Do you have dual coverage: Yes No If yes: _____

Insured's Name _____ Insured"s Employer _____

Insurance Company _____ Insured's ID # _____ Group No. _____

Insurance Co. Address _____
Street City State Zip

Signature (Parent's signature if minor) _____

( see other side )

Patient Name _____ Date _____

Family Dentist _____ Physician _____

## MEDICAL HISTORY

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Date of last physical examination _____ |
| ☐ | ☐ | Are you currently under treatment for a physical or emotional problem? |
| ☐ | ☐ | Has there been any change in your general health or weight during the past year? |
| ☐ | ☐ | Are you taking any drugs or medication (including oral contraceptives or hyperkinetic drugs)? |
| ☐ | ☐ | Are you allergic to any drugs (including aspirin, penicillin or codeine)? |
| ☐ | ☐ | Have you been hospitalized for any operations or radiation treatment? |
| ☐ | ☐ | Have you ever had a serious accident involving head injuries? |
| ☐ | ☐ | Do you smoke or use any tobacco products? |

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Blood disorder, anemia or bleeding problems? | ☐ | ☐ | Fainting spells, epilepsy or stroke? |
| ☐ | ☐ | Liver disease, hepatitis or jaundice? | ☐ | ☐ | Glaucoma, or other eye disorders? |
| ☐ | ☐ | Cardiovascular disease (heart attack, high/low blood pressure)? | ☐ | ☐ | Allergies, asthma, or hay fever? |
| ☐ | ☐ | Sinus trouble, tonsilitis, sore throat, or ear infection? | ☐ | ☐ | Thyroid or endocrine problems? |
| ☐ | ☐ | Ulcers, stomach, intestinal or bowel problems? | ☐ | ☐ | Congenital heart defects? |
| ☐ | ☐ | Rheumatic fever or rheumatic heart diseases? | ☐ | ☐ | Diabetes? |
| ☐ | ☐ | X-ray or chemo-therapy for a tumor? | ☐ | ☐ | Communicable disease? |
| ☐ | ☐ | Physical handicaps, mental retardation? | ☐ | ☐ | Are you pregnant? |
| ☐ | ☐ | Emotional problems, psychiatric care, alcoholism or drug addiction? | ☐ | ☐ | Kidney disease? |
| ☐ | ☐ | Respiratory disease, pneumonia, tuberculosis, shortness of breath | ☐ | ☐ | Have you reached puberty? |

Please describe any other disease, condition, problems or current medical treatment, including impending operations, recent injuries or other information the doctor should be aware of:

_____

_____

_____

## DENTAL HISTORY

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Date of last dental examination_____ |
| ☐ | ☐ | Are you allergic to any local anesthetics (Novocain, Xylocain)? |

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| ☐ | ☐ | Previous orthodontic consultation or treatment? |
| ☐ | ☐ | Periodontal surgery or treatment? |
| ☐ | ☐ | Treatment for a temporomandibular joint disorder? |
| ☐ | ☐ | Clicking or soreness when the mouth is opened? |
| ☐ | ☐ | Oral surgery or x-ray treatment of the jaws, mouth or lips? |
| ☐ | ☐ | Teeth extracted or missing? |
| ☐ | ☐ | Problems with bleeding or gum healing after surgery? |
| ☐ | ☐ | Injuries to face, mouth, or teeth? |

| | | |
|---|---|---|
| ☐ | ☐ | Grinding / clenching teeth? |
| ☐ | ☐ | Sensitivity to heat,cold or sweets: |
| ☐ | ☐ | Fluoride treatments? |
| ☐ | ☐ | Speech therapy? |
| ☐ | ☐ | Other : |

I certify that the above information is true and complete to the best of my knowledge.

Signature

Date

Doctor

Date