MERIDIAN PARK ORTHODONTICS

Medical & Dental History for Patients Age 18 and Over

Welcome! Please Tell Us About Yourself

Last Name First M.I.

I prefer to be called

Birth date Age

Address

City State Zip

How long have you lived at this address?

□ Single □ Married □ Divorced □ Widowed □ Separated

Home phone

Cell phone

Work phone

Email address (appointment reminders will be sent to this address)

Employer/Business Name

Occupation

In the event of an emergency, who should we contact?

Name

Relationship to patient

Home phone

Cell phone

Work phone

Dentist

Name City

Last seen Reason

Where X-rays taken? □ Yes □ No □ Don't know

Other dentists/dental specialists now being seen

Name City

Reason

Physician

Name City

Phone

Last seen Reason

Other physicians/health care providers now being seen

Name Phone

Reason

General Information

What concerns you about your teeth? What would you like orthodontic treatment to accomplish?

Who suggested that you might need orthodontic treatment?

Why did you select our office?

Have you had any previous orthodontic treatment? □ Yes □ No
Please describe:

Have you consulted with another orthodontist? □ Yes □ No

Would you mind wearing braces? □ Yes □ No

Do you think any of your work or activities might affect your teeth or jaws? □ Yes □ No Please explain

Have any other family members or friends been treated in this office? □ Yes □ No Please name them

Do you have any other family members possibly interested in orthodontic treatment now or in the future? □ Yes □ No

Financial Responsibility

Who is financially responsible for this account?

If different than patient, please complete information below:
Address

Home phone Cell phone

Email

Relationship to patient

Employer

Dental Insurance

Policy holder's full name

Policy holder's birth date

Relationship to patient

Address and phone (if not listed above)

Employer

Ins. Co. Name

Member ID #

Group #

Does this policy have orthodontic benefits?
□ Yes □ No □ Don't know

Do you have a secondary policy? □ Yes □ No

 Patient Name_____

Medical History

Now, or in the past, have experienced any of the following:

Y N	Birth defects or hereditary problems	Y N	Bone fractures or major injuries	Y N	Any injury to face, head, neck
Y N	Arthritis or joint problems	Y N	Endocrine or thyroid problems	Y N	Diabetes or low blood sugar
Y N	Kidney problems	Y N	Cancer, tumor, radiation or chemotheraphy	Y N	Stomach ulcer or acid reflux
Y N	Immune system problems	Y N	Substance abuse	Y N	AIDs or HIV positive
Y N	Hepatitis, jaundice or other liver problem	Y N	Polio, mononucleosis, tuberculosis, pneumonia	Y N	Seizures, fainting spells, neurologic problem
Y N	Mental illness or depression	Y N	Vision problems	Y N	Hearing problems
Y N	Eating disorders	Y N	High or low blood pressure	Y N	Excessive bleeding or anemia
Y N	Chest pain or shortness of breath	Y N	Heart defects, hear murmur, rheumatic heart disease	Y N	Stroke or heart attack
Y N	Skin disorder (other than acne)	Y N	Frequent headaches or migraines	Y N	Frequent ear or throat infections
Y N	Asthma or sinus problems	Y N	Tonsil or adenoid conditions	Y N	Use of cigarettes or cigars
Y N	Use of smokeless tobacco	Y N	Osteoporosis or bone disorders	Y N	Treatment with bisphosphonate medications (Fosamax, Boniva, Actonel, didronel, Aredia,
Y N	Women, are you pregnant?	Y N	Women, are you trying to become pregnant?	Y N	Other illness or medical conditions_____

Have you had **allergies** or reactions to any of the following:

Y N	Latex	Y N	Local anesthetics (novocaine, lidocaine, xylocaine)	Y N	Penicillin
Y N	Other antibiotics	Y N	Metals (jewelry, clothing snaps)	Y N	Other substances or medications_____

Please list any **medications** or supplements that you take

_____ Taken for _____

_____ Taken for _____

Do you take antibiotic pre-medication before dental procedures? □ Yes □ No

Dental History

Now or in the past, have experienced any of the following:

Y N	Permanent teeth removed or missing	Y N	Sucked thumb or fingers
Y N	Chipped or injured teeth	Y N	Sensitive or sore teeth
Y N	Bleeding gums, bad taste or mouth odor	Y N	Jaw cysts or infections
Y N	Frequent canker sores or cold sores	Y N	Speech problems or speech therapy
Y N	Difficulty breathing though nose or frequent mouth breathing	Y N	Snoring
Y N	Abnormal swallowing (tongue thrust)	Y N	Tooth grinding or clenching
Y N	Clicking or popping of the jaw joint	Y N	Difficulty opening or closing jaw
Y N	Soreness in jaw or facial muscles	Y N	Treatment for TMJ or TMD
Y N	Serious difficulty associated with dental treatment	Y N	Diagnosis or treatment for gum (periodontal) disease

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____