

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Are you in good health? Yes No
Are you under the care of physician for a specific problem at this time? Yes No Illness: _____
Please list any medications you are currently taking and why: _____
Please list any drug allergies or sensitivities: _____
Do you have a history of a serious illness, accident, or operation? Yes No Please Describe: _____
Have you ever smoked or chewed tobacco? Yes No For how long? _____
Females only: Are you pregnant? Yes No

Please CIRCLE any of the following medical conditions that apply

- Diabetes Epilepsy Dizziness Rheumatic Fever Abnormal Bleeding / Hemophilia
- Pneumonia Arthritis HIV / AIDS Ear Infections / Tubes Prolonged Bleeding
- Bone Disorders Herpes Asthma High Blood Pressure Radiation/Chemotherapy
- Heart Murmur Anemia Cancer Rheumatic Fever Congenital Heart Defect
- Heart Problems Tuberculosis Kidney problems Emotional / Nervous Disorders

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 _____
What concerns you most about your teeth? _____
Yes No Are you presently in any dental pain? If Yes, please describe: _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to your face, mouth, or teeth? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you had your wisdom teeth removed?
Yes No Are you a mouth breather?
Yes No Do your gums bleed when brushing?
Yes No Is any part of your mouth sensitive to temperature or to pressure? If Yes, where? _____

Please CIRCLE any of the following that apply

- Clenching / Grinding Teeth Jaw Joint Soreness Frequent Tension Headaches
 - Jaw Joint Clicking or Popping Frequent Ringing in the Ears Head and Neck Muscle Soreness
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Are you open to the idea of permanent teeth being removed if necessary for treatment?
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes No Are you aware that some appointments will be during work hours?

BENEFITS

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 or change in the position of the teeth after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and 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. Kelly Mitchell & Dr. Brian Bartlett to perform a complete orthodontic evaluation.

Signature : _____ Date: _____

THANK YOU!