



— ORTHODONTICS —
The Road To A Beautiful Smile

Welcome To Our Office

Today's Date _____

Please print clearly

Your medical and dental history are essential for the determination and course of your treatment in our office. It is important that you complete this questionnaire accurately as it will become part of your office record. Be assured that it will be held in the strictest of confidence.

Dr. Mrs. Mr. Ms. Last Name _____ First Name _____ Middle Initial ____ Birth Date (Y/M/D) ____ / ____ / ____

Home Address _____ Apt.# _____ City _____ Postal Code _____

Home Te. Number (____) _____ Business Tel. Number (____) _____ Cell (____) _____

Occupation _____ Employer _____ Do you have dental insurance? Yes No

Name of Insurance Company _____ Policy # _____ Certificate / I.D. # _____

Name of Spouse/Parent _____ Business Tel. (____) _____

Family Dentist _____ Tel. Number (____) _____

Family Physician _____ Tel. Number (____) _____

Who may we thank for referring you to us? _____ Nickname: _____

Health History

How are you feeling? I am: RELAXED NERVOUS TERRIFIED

Have you ever had an unfavourable reaction following dental treatment?
Please discuss this with the doctor. YES NO

Female patients, are you or could you be pregnant or nursing? YES NO

Check any of the following which you have or have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart trouble/Angina | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Neck injury |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cortisone treatment | <input type="checkbox"/> Cancer treatment |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Hemophillia | <input type="checkbox"/> Migraine/Headaches | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Artificial valve, joint, or prosthesis |
| <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> HIV + /Aids | <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Tuberculosis (TB) |

Do you have or have you had any other diseases or medical problems not listed on this form? _____

Please list allergies to medications/other substances

Please list medications currently being taken (include non-prescription drugs)

Dental History

Reason for visiting (How can we help you) _____

Are you presently in pain? YES NO

Are any of your teeth sensitive to the following?

- Hot Cold Biting Pressure
- Sweets Other _____

I herby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if any medicines change, I will inform the doctor at the next appointment without fail, if deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

If you have any questions regarding insurance, billing or financial policy feel free to discuss this with our receptionist.

Broken appointments and surgical intervention may constitute an additional fee. All fees are payable upon completion of treatment.

Financial Policy: The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but business like understanding between doctor and patient. We feel that misunderstandings can be minimized if financial policies are made to acquaint you with our policy.

Signature _____

Date _____