

MB Orthodontics, PLLC

ADULT PATIENT INFORMATION

TITLE Dr. Mr. Miss Ms. Mrs.

NAME _____ PREFERRED NAME _____

BIRTHDATE _____ AGE _____ GENDER MALE FEMALE

ADDRESS (home) _____ # OF YEARS @ ADDRESS _____

PHONE (home) _____ (work) _____ (cell) _____

EMAIL _____ SSN _____

EMPLOYER _____ # OF YEARS _____ OCCUPATION _____

DENTIST _____ DATE OF LAST VISIT _____

HAS PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? YES NO IF SO, WHERE? _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

ADDRESS (home) _____

PHONE (home) _____ (work) _____ (cell) _____

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? _____

WHOM MAY WE THANK FOR REFERRING YOU TO MB ORTHODONTICS? _____

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that it is our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME _____ SIGNATURE _____ DATE _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, have you had:

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, or major injuries?
- yes no dk/u Any injuries to face, head, neck?
- yes no dk/u Arthritis or joint problems?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Diabetes or low sugar?
- yes no dk/u Kidney problems?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer, hyperacidity, acid reflux?
- yes no dk/u Immune system problems?
- yes no dk/u History of osteoporosis?
- yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or other liver problem?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Seizures, fainting spells, neurologic problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u Vision, hearing, or speech problems?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u High or low blood pressure?
- yes no dk/u Excessive bleeding or bruising, anemia?
- yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
- yes no dk/u Heart defects, heart murmur, rheumatic heart disease?
- yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
- yes no dk/u Skin disorder (other than common acne)?
- yes no dk/u Do you eat a well-balanced diet?
- yes no dk/u Frequent headaches or migraines?
- yes no dk/u Frequent ear infections, colds, throat infections?
- yes no dk/u Asthma, sinus problems, hayfever?
- yes no dk/u Tonsil or adenoid condition?
- yes no dk/u Do you frequently breathe through your mouth?

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

- yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin
- yes no dk/u Other antibiotics
- yes no dk/u Metals (jewelry, clothing snaps)
- yes no dk/u Acrylics

- yes no dk/u Plant pollens
- yes no dk/u Animals
- yes no dk/u Foods
- yes no dk/u Other substances _____

DENTAL HISTORY

Now or in the past, have you had:

- yes no dk/u Permanent or extra (supernumerary) teeth removed?
- yes no dk/u Supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Chipped or injured primary or permanent teeth?
- yes no dk/u Any sensitive or sore teeth?
- yes no dk/u Bleeding gums, bad taste or mouth odor?
- yes no dk/u Jaw fractures, cysts, infections?
- yes no dk/u Any teeth treated with root canals or pulpotomies?
- yes no dk/u "Gum boils," frequent canker sores or cold sores?
- yes no dk/u History of speech problems or speech therapy?
- yes no dk/u Difficulty breathing through nose?
- yes no dk/u Food impaction between the teeth?
- yes no dk/u Mouth breathing habit or snoring at night?
- yes no dk/u History of speech problems?
- yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
- yes no dk/u Teeth causing irritation to lip, cheek or gums?
- yes no dk/u Abnormal swallowing (tongue thrust)?
- yes no dk/u Tooth grinding or clenching?
- yes no dk/u Clicking, locking in jaw joints?
- yes no dk/u Soreness in jaw muscles or face muscles?
- yes no dk/u Ringing in ears, difficulty in chewing or opening jaw?
- yes no dk/u Have you ever been treated for "TMJ" or "TMD" problems?
- yes no dk/u Any broken or missing fillings?
- yes no dk/u Any serious trouble associate with previous dental treatment?
- yes no dk/u Have you ever been diagnosed with gum disease or pyorrhea?
- yes no dk/u Have you ever had an orthodontic consultation or treatment before now?

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

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

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____

How often do you floss? _____

Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

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/her 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 _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Patient Signature _____

Date _____

Dental Staff Signature _____

Date _____

Changes _____

Patient Signature _____

Date _____

Dental Staff Signature _____

Date _____

Changes _____

Patient Signature _____

Date _____

Dental Staff Signature _____

Date _____