



**Patient's Medical/Dental History**

Patient's Dentist: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Last Visit: \_\_\_\_\_

What is patient's/parent's primary concern: \_\_\_\_\_

Patient's Physician: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Last Visit: \_\_\_\_\_

Is patient presently being treated by a physician? Yes No Why?: \_\_\_\_\_

Has the patient's tonsils and adenoids been removed? Yes No Is child adopted? Yes No

Has the patient ever had an unusual reaction to any drug? Yes No Is child aware of adoption? Yes No

Does patient have a speech problem, if so are they receiving therapy? Yes No

Has the patient any of the following?

- Heart Murmur
- Rheumatic Fever
- Mitral Valve Prolapse
- Pre Medication Required
- Anemia
- Bleeding Problems
- Gum Problems
- Tuberculosis
- Diabetes
- Epilepsy
- Convulsions/Seizures
- Immune Deficiency
- Smoke Cigarettes/Cigars
- Asthma
- Breathing Problems
- Frequent Colds
- Sinus Problems
- Cold Sores
- ADD/ADHD
- Ulcers
- Thyroid/Hormonal Imbalance
- Lip Biting
- Nail Biting
- Tongue Thrusting
- Presently Suck Thumb/Finger
- Arthritis
- Problems Opening/Closing
- Chewing Problems
- Jaw Popping
- Grinding/Clenching
- Concussion
- Injury to Teeth/Jaws
- Severe Headaches
- Facial Pain
- Any TMJ History
- Nervous Disorder
- Hearing Problem
- Latex Allergy
- Metal Allergy
- Seasonal Allergy
- Other Allergy: List: \_\_\_\_\_
- Major Surgery

Has Patient ever had orthodontic treatment or worn a retainer? Yes No

Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: \_\_\_\_\_

If Female: Menstruating? Yes No Date of First Period: \_\_\_/\_\_\_/\_\_\_

If Male: Voice Change? Yes No Date Started: \_\_\_/\_\_\_/\_\_\_ Shaving? Yes No Date Started: \_\_\_/\_\_\_/\_\_\_

Names of Daily Medications? \_\_\_\_\_

Is there any other information about the patient's health we should know? \_\_\_\_\_

**Whom may we thank for the referring you to our office?**

Please circle all that apply:

My Dentist    Staff Member at My Dentist Office    Selected Doctor from Insurance Provider List

BraceTown Orthodontics Website    Invisalign® Website    Yellow Page Ad    Newspaper Ad in: \_\_\_\_\_

My Friend/Relative Referred Me (list name(s)): \_\_\_\_\_

Other (please specify): \_\_\_\_\_

Signature (Parent's if minor): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_