

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

Are you currently under medical treatment?... Yes No

Please explain: _____

Are you taking any medications(s)? Yes No

If yes, please list and explain _____

Have you taken, or are you taking any bisphosphonates. If yes, for what condition? _____

Are you or could you be pregnant?..... Yes No

ALLERGIES Yes No

Are you allergic to or have you had any reactions to:

Penicillin/Amoxicillin..... Yes No

Other Antibiotics Yes No

If yes, please list _____

Metals..... Yes No

Latex Products Yes No

Other Yes No

If yes, please explain _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Yes No Yes No

High Blood Pressure..... Yes No

Rheumatic Fever..... Yes No

Heart Murmur..... Yes No

Mitral Valve Prolapse..... Yes No

Heart Conditions..... Yes No

Epilepsy/Convulsions..... Yes No

Fainting/Seizures..... Yes No

Hay Fever/Allergies..... Yes No

ADHD..... Yes No

Any developmental /genetic issues that would effect how we communicate with your child? _____

Tuberculosis..... Yes No

Thyroid Problems..... Yes No

Kidney Diseases..... Yes No

Respiratory Problems..... Yes No

Diabetes..... Yes No

Asthma Yes No

X-ray/Radiation (Cancer) Therapy..... Yes No

AIDS or HIV Infection Yes No

Hepatitis/Jaundice ... Yes No

Other Yes No

If yes, explain: _____

PATIENT DENTAL HISTORY

Dentist: _____

Name Address Phone Date of Last Appointment

Do you authorize release of information about orthodontic treatment to the patient's dentist Yes No

Yes No Yes No

Do your gums bleed while brushing or flossing?..... Yes No

Are your teeth sensitive to:

hot or cold food/liquids? Yes No

sweet or sour foods/liquids?..... Yes No

Do you feel pain in any of your teeth? Yes No

Do you have any or frequently get sores in or around your mouth? Yes No

Have you had any head, neck or jaw injuries?..... Yes No

Have you ever experienced any of the following problems in your jaw? Yes No

-Clicking? Yes No

-Pain? Yes No

-Difficulty in opening or closing? Yes No

-Difficulty in chewing? Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks? Yes No

Have you had any blows to your teeth? ... Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you ever had any prolonged bleeding following extractions? Yes No

Have you had prior orthodontic:

-Treatment? Yes No

-Consultation? Yes No

Do you have, or have you had thumb/finger habit? Yes No

PLEASE EXPLAIN THE NATURE OF THE ORTHODONTIC PROBLEM IN YOUR OWN TERMS:

AUTHORIZATION AND RELEASE

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Simi to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child for orthodontic care to the patient's general dentist, third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Simi, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient or parent if patient is a minor

_____/_____/_____
Date

Doctor's Comments:

Date Reviewed: _____

Date Reviewed: _____

Date Reviewed: _____

Rvsd:10/10