LAWTON ORTHODONTICS

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DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

American Association of Orthodontists

2984 Alafaya Trail
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Medical and Dental Information Adult General Information

Patients Last Name_____First_____Middle_____Nickname_____

SS#_____-_____-_____ Age_____ Date of Birth____/____/____ Sex: ☐ M ☐ F Married ☐ Single ☐ Divorced ☐ Separated ☐

Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Home Phone_____Work_____Cell_____

Occupation_____Employer_____How Long?_____

Name of Spouse_____Telephone_____SS#_____

Spouse's Occupation_____Employer_____How Long?_____

E-Mail_____Spouse's E-mail_____

Orthodontic Insurance? Yes ☐ No ☐ If yes, Please Fill Out Insurance Information Form

If you are completing this form for another person, what is your relationship to that person?_____

In case of emergency, notify_____ Telephone_____

WHOM MAY WE THANK FOR THIS REFERRAL?_____

Medical History

The patient's Medical and Dental History Information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions. If additional space is needed, please use the back of this form.

1. Are you in good health? ..... ☐ Yes ☐ No
2. My last physical exam was on:_____
3. Are you now under the care of a physician? ..... ☐ Yes ☐ No
   If so, what is the condition being treated?_____
4. The names of my physicians are:_____
5. Are you taking any medicines, including non-prescription medicines? ..... ☐ Yes ☐ No
   If so, what medicines are being taken? _____
6. Have you had any serious illness, operation, or been hospitalized in the past five years? ..... ☐ Yes ☐ No
   If so, what was the illness or problem?_____
7. Have you had any injuries to the face head or teeth? ..... ☐ Yes ☐ No
   If so what, injury and when_____
8. Do you have, or have you had, any of the following diseases or problems?
   - A. Damaged heart valves or artificial heart valves, *including heart murmur or rheumatic heart disease, scarlet fever, artificial joints*? ☐ Yes ☐ No
   - B. Cardiovascular disease (*heart trouble, heart attack, angina, coronary insufficiency, coronary inclusion, arteriosclerosis, stroke*) ..... ☐ Yes ☐ No
   - C. High blood pressure ..... ☐ Yes ☐ No
   - D. Low blood pressure. ..... ☐ Yes ☐ No
   - E. Environmental allergies hayfever, etc. ..... ☐ Yes ☐ No
   - F. Sinus trouble ..... ☐ Yes ☐ No
   - G. Asthma ..... ☐ Yes ☐ No
   - H. Fainting spells or seizures, dizziness ..... ☐ Yes ☐ No
   - I. Diabetes ..... ☐ Yes ☐ No
   - J. Hepatitis jaundice or liver disease ..... ☐ Yes ☐ No
   - K. AIDS, HIV infection or positive HIV test ..... ☐ Yes ☐ No
   - I. Thyroid problems ..... ☐ Yes ☐ No

M. Respiratory problems, emphysema, bronchitis, etc.? ..... ☐ Yes ☐ No
N. Arthritis or painful swollen joints? ..... ☐ Yes ☐ No
O. Stomach ulcer or hyperacidity? ..... ☐ Yes ☐ No
P. Kidney trouble ..... ☐ Yes ☐ No
Q. Epilepsy or other neurological disease? ..... ☐ Yes ☐ No
R. Women: are you pregnant? ..... ☐ Yes ☐ No
S. Do you have any blood disorder, such as anemia, hemophilia, leukemia, sickle cell anemia? ..... ☐ Yes ☐ No
T. Are you allergic or have you had a reaction to:
1. Local anesthetics ..... ☐ Yes ☐ No
2. Penicillin or other antibiotic's ..... ☐ Yes ☐ No
3. Latex ..... ☐ Yes ☐ No
4. 0ther_____
U. Have you had any problems associated with any previous dental treatment? ..... ☐ Yes ☐ No
If so, explain_____
W. Do you have any disease, condition, or problem not listed above that you think I should know? ..... ☐ Yes ☐ No
If so explain_____

Dental information

1. When was patients last dental visit?_____
2. The name of the dentist is:_____
3. Have you ever had teeth removed? ..... ☐ Yes ☐ No
4. Have you had your wisdom teeth removed? ..... ☐ Yes ☐ No
5. What is your main reason for seeking orthodontic treatment?_____
6. Have you ever worn braces and/or retainers? ..... ☐ Yes ☐ No
If yes, when and by whom?_____
7. Have you ever had orthodontic examination, evaluation, conference or consultation? ..... ☐ Yes ☐ No
If yes, when and by whom?_____
8. Have you ever had orthodontic records, such as x-rays, study models or photographs? ..... ☐ Yes ☐ No
If yes, when and by whom?_____
9. Have you ever been told you have gum disease? ..... ☐ Yes ☐ No
10. Have you ever been advised to have periodontal (gum) treatment? ..... ☐ Yes ☐ No
11. Have you ever had periodontal (gum) treatment? ..... ☐ Yes ☐ No
If so when and by whom?_____
12. Does (do) your jaw joint(s) click, crack, pop, grate or make any other sound(s)? ..... ☐ Yes ☐ No
If yes, please explain_____
13. Do you grind or clinch your teeth? ..... ☐ Yes ☐ No
If so when?_____
14. Has your jaw ever "locked" open or closed? ..... ☐ Yes ☐ No
If yes, please explain_____
15. Have you ever been told that you have TMJ or "Jaw Joint" problems? ..... ☐ Yes ☐ No
If yes, when and by whom?_____
16. Have you ever had treatment for TMJ or "Jaw Joint" problems? ..... ☐ Yes ☐ No
If yes, when and by whom?_____
17. Has any member of your family received orthodontic treatment? ..... ☐ Yes ☐ No
18. If we have treated a family member or friend, please name_____
19. In your own words, what is your problem?_____

The medical/dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s). I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment. The above information will be kept in strict confidence.

Signature_____ Date_____
Additional Information/Comments_____