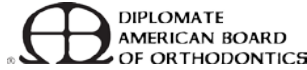




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Medical and Dental Information Adult General Information

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. Other _____
- 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 clench 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 changes(s). I understand that, where appropriate, credit bureau reports maybe obtained. Thank you for your cooperation. The above information is important in your diagnosis and treatment, and will be kept in strict confidence.

Signature _____ Date _____

Additional Information/Comments _____
