PAGE • CONDICT ORTHODONTICS

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Practice limited to Orthodontics

ADULT HISTORY

Today's date _____

Patient's Name _____ (First) _____ (Middle Initial) _____ (Last) _____ (Date of Birth)

Patient's Address _____ (Street) _____ (City) _____ (Zip Code) _____ (Home Phone) _____ (Cell Phone)

Employer _____ Business Phone _____

Family Dentist _____ Address _____

How did you hear about our office? Internet? __ Insurance?__ Referral? __ If so, whom? _____ Other? __ (Please check one)

Would you like to receive text messages for appointment reminders? If so, please list up to 3 cell phone numbers to receive text messages:

_____ E-mail _____

INSURANCE

Is there insurance covering orthodontics?_____ Name of insurance carrier _____

Phone # and address of insurance carrier_____

Employee Name _____ Group # _____ Employer Name _____

Employee ID #_____ Employee Date of Birth _____

MEDICAL HISTORY

Present state of health: _____ Excellent _____ Good _____ Fair _____ Poor

Currently under physician's care? __ Yes __No Why? _____

Currently taking medication? __Yes __ No What? _____ Are you currently taking medication for osteoporosis? _____Yes _____ No

Is there any history of:

_____ Speech problems _____ Bleeding disorders _____ Birth defects

_____ Facial injuries _____ Facial operations _____ Vision impairment

_____ Hearing problems _____Osteoporosis _____ Asthma, sinus trouble, hayfever

_____ Bone fractures/major accidents _____ Rheumatoid or arthritic conditions _____ Cancer, tumor, radiation, or chemotherapy

_____ Frequent headaches _____ Frequent colds or sore throats _____ Tonsil or adenoid conditions

_____ Cardiovascular problem (heart murmur, rheumatic heart disease, congenital heart defects, etc.)

Please explain any of the above positive responses: _____

_____

Allergies or reactions to the following:

_____ Local anesthetics (novacaine or lidocaine) _____ Aspirin _____ Ibuprofen (Advil, Motrin)

_____ Penicillin or other antibiotics _____ Latex (gloves) _____ Vinyl

_____ Metals (jewelry, clothing snaps) _____ Acrylic _____ Other substances (specifiy)

Other Allergies? – Please list: _____

Serious Illnesses? Operations? _____

Noblesville 110 Lakeview Drive, Noblesville IN 46060 (317) 773-0016
Tipton 402 Fairgrounds Road, Doctor's Park, Tipton IN 46072 (765) 675-8080

DENTAL HISTORY

Have you had: _____ Regular dental check-ups _____ X-rays _____ Impressions _____ Extractions

DENTAL and ORTHODONTIC INFORMATION

Now, or in the past, have you had:

_____ Tooth grinding _____ Clenching _____ Mouth breathing _____ Tongue thrust

_____ Injury to teeth, face, or jaw _____ Teeth sensitive to hot/ cold or toothache _____ Jaw fractures/cysts/infections

_____ Root canals or "dead" teeth _____ Periodontal "gum" problems _____ Ringing in ears

_____ Headaches _____ Pain/soreness in muscles of face _____ Difficulty chewing or opening jaw

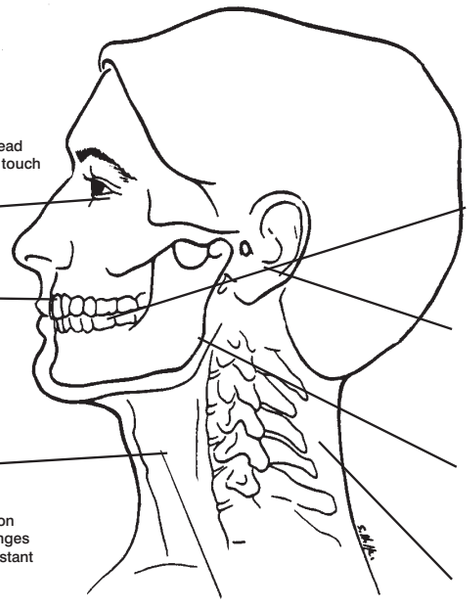
_____ Jaw pain _____ Jaw clicking/popping/locking _____ Teeth irritating cheek, lip, tongue, or palate

_____ Frequent cold sores _____ Headaches

_____ Any relative with similar tooth or jaw relationships _____ Concerned about spaced, crooked, or protruding teeth

_____ Ever had a prior orthodontic exam or treatment _____ Aware or concerned about an under or over-developed jaw

Please circle any of the following systems you have had or currently have:



HEAD PAIN, HEADACHE
1. Forehead
2. Temples
3. 'Migraine' type
4. Sinus type
5. Shooting pain up back of head
6. Hair and/or scalp painful to touch

EYES
1. Pain behind eye
2. Bloodshot eyes
3. May bulge out
4. Sensitive to sunlight

MOUTH
1. Discomfort
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side when opening
5. Locks shut or open
6. Can't bite

THROAT
1. Swallowing difficulties
2. Laryngitis
3. Sore throat with no infection
4. Voice irregularities or changes
5. Frequent coughing or constant clearing of throat
6. Feeling of foreign object

TEETH
1. Clinching, grinding at night
2. Looseness and soreness of back teeth

EAR PROBLEMS
1. Hissing, buzzing or ringing
2. Decreased hearing
3. Ear pain, ear ache, no infection
4. Clogged "itchy" ears
5. Vertigo, dizziness

JAW PROBLEMS
1. Clicking, popping jaw joints
2. Grating sounds
3. Pain in cheek muscles
4. Uncontrollable jaw movements

NECK PROBLEMS
1. Lack of mobility, stiffness
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side when opening
5. Locks shut or open
6. Can't bite

Previous orthodontic treatment ? Self ___ Yes ___ No Others in family? ___ Yes ___ No

If so, with what result? Self: ___ Excellent ___Good ___Poor Others in family: ___Excellent ___Good ___Poor

What do you consider to be the main benefits of orthodontic correction?

___ Cosmetic ___ Functional ___ Psychological/ Emotional Other _____

Are you self-conscious about your teeth? _____ Yes _____ No

What is your primary concern? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed _____ Date _____
Patient

Signed _____ Date _____
Witness

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