PAGE • CONDICT ORTHODONTICS

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Practice limited to Orthodontics

Today's date ______________

ADULT HISTORY

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? ____

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

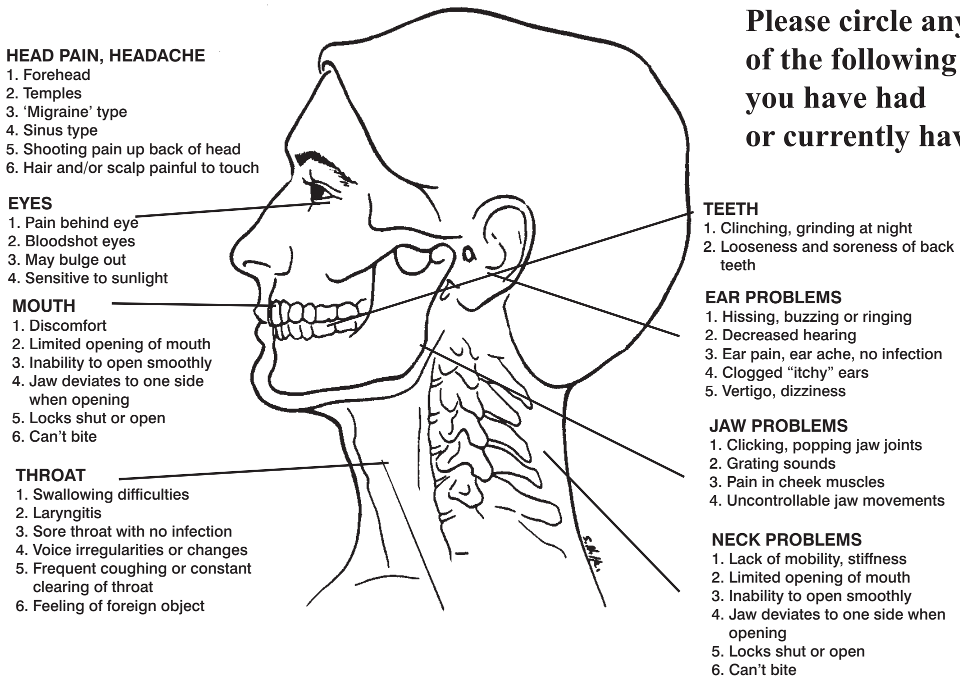
_____ Jaw pain _____ Jaw clicking/popping/locking _____ Teeth irritating cheek, lip, tongue, or palate

_____ 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:



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

Noblesville 110 Lakeview Drive, Noblesville IN 46060 (317) 773-0016

Tipton 402 Fairgrounds Road, Doctor's Park, Tipton IN 46072 (765) 675-8080