BRACES IN ORLEANS
CREATING BEAUTIFUL SMILES

Your cooperation in completing this form is vital to a proper orthodontic evaluation. All information is strictly confidential and will remain with this office. Please notify your orthodontist at once of any information changes while you are in treatment.

We appreciate referrals. Whom may we thank for referring you?_____

What is the reason for your consultation?_____

CONFIDENTIAL PATIENT INFORMATION

Name_____
Last First Middle

Address_____
Street Apt City Prov Postal Code

Cell Phone _____2nd phone_____ Other phone_____
E-mail_____Fax_____
In case of emergency_____
Name Relationship Phone

Date of Birth ____/_____/_____ Gender _____ School or Employer_____
Day Month Year

Person responsible for account: same as above U or _____
Name Address

ORAL HEALTH HISTORY

Have you been under regular care by a dentist? Yes No
Dentist: _____Date of last examination :_____
Have you ever had any orthodontic consultations?
Yes No
Have you previously had orthodontic treatment? Yes No
Is there any history of:

Speech problems	Yes	No
Thumb or finger sucking	Yes	No
Injuries to the face, mouth or teeth	Yes	No
TMJ or jaw joint pain	Yes	No
Grinding/clenching teeth	Yes	No
Difficulty chewing	Yes	No
Mouth breathing	Yes	No

List any musical instruments played by the patient_____

MEDICAL HISTORY

Physician:_____
Are you under a physician's care presently? Yes No If yes, for what?:_____
Date of last physical exam_____
Are you currently being treated for some illness or condition? Yes No
Have you ever had a serious illness or operation? Yes No
If yes, what was the problem?_____
Have you ever been told you need to be premedicated or to take antibiotics before dental treatment? Yes No
If yes, for what? _____
Are you presently taking any medications either prescribed by a doctor or purchased over the counter? Yes No
If yes, what? _____
Do you have allergies? Yes No
If yes, to what? _____
_____

Do you have or have you had any of the following?

Rheumatic heart disease/Rheumatic fever	Yes	No	Artificial joints/bones	Yes	No
Heart murmur/Mitral Valve prolapse	Yes	No	Seizures, epilepsy	Yes	No
Congenital heart disease	Yes	No	Ulcers	Yes	No
Heart Attack	Yes	No	Diabetes	Yes	No
Shortness of breath/chest pains	Yes	No	Kidney disease	Yes	No
High blood pressure	Yes	No	Tuberculosis	Yes	No
Arteriosclerosis, High cholesterol	Yes	No	Sexually transmitted disease	Yes	No
Stroke	Yes	No	Hepatitis, jaundice or liver disease	Yes	No
Asthma	Yes	No	AIDS/HIV+	Yes	No
Hives/skin rash	Yes	No	Bruise easily	Yes	No
Thyroid disease	Yes	No	Respiratory disease	Yes	No
Shortness of breath	Yes	No	Anemia, sickle cell disease/trait	Yes	No
Arthritis	Yes	No	Hemophilia/bleeding disorder	Yes	No
Sinus trouble, hay fever	Yes	No	Fever blisters/cold sores	Yes	No
Mental health/behavioral problems	Yes	No	Severe headaches	Yes	No
Nervous problems	Yes	No	Cancer/chemotherapy	Yes	No
Dizzy spells	Yes	No	Are you a smoker or tobacco user?	Yes	No

If you answered YES to any of the above, please elaborate:

_____

_____

_____

_____

_____

For women only:

Are you pregnant?	Yes	No
Do you have problems with menstruation?	Yes	No

Do you have any disease, condition, or problem not listed above that you think is important? Yes No

If so, please explain _____

_____

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

_____ _____

Signature of patient/guardian Date Signature of Orthodontist Date

Medial History Update or Changes:

Date	Comments	Signature