Deukmedjian
ORTHODONTICS

Please circle yes or no to all of the following questions. *The answers are for the office records only and will be considered confidential.* A thorough and complete history is vital to a proper orthodontic evaluation. Do you have or have you had any of the following?

Medical History

Birth defects or hereditary problems	y	n
Bone fractures, any major accidents	y	n
Rheumatoid or arthritic conditions	y	n
Endocrine or thyroid conditions	y	n
Kidney problems	y	n
Diabetes	y	n
Cancer or been treated for a tumor	y	n
Stomach ulcer or hyperacidity	y	n
Polio, mononucleosis, tuberculosis, or pneumonia	y	n
Problems of the immune system	y	n
Hepatitis, Jaundice or liver problem	y	n
Fainting spells, seizures, epilepsy or neurologic disease	y	n
Mental health or behavior problems	y	n
Vision, hearing, tasting or speech difficulties	y	n
Excessive bleeding, anemia or bleeding tendency	y	n
High or low blood pressure	y	n
Easily tired	y	n
Chest pain, shortness of breath or swollen ankles	y	n
Cardiovascular (Heart) problems	y	n
Skin disorder	y	n
Do you have a normal/good diet	y	n
Frequent headaches/colds/sore throat	y	n
Any history of speech problems	y	n
Eye, ear, nose throat condition	y	n
Hayfever, asthma, sinus trouble, hives	y	n
Tonsils or adenoid conditions	y	n
Tonsils removed	y	n
Allergies or drug reactions	y	n
Have you ever used Fen-Phen	y	n

For how long? _____

Are you taking medication, nutrient supplements, or non-prescription medicine	y	n
Do you take antibiotics for dental visits	y	n

Date of last physical exam _____

Dental History

Please list them _____

Are you excited about getting braces	y	n
Injured baby or permanent teeth?	y	n
Jaw fractures, cysts, mouth infections	y	n
Root canals treated	y	n
Periodontal (Gum) disease	y	n
Frequent canker sores or cold sores	y	n
Thumb or finger sucking habit	y	n

If yes, until age _____

Abnormal swallowing habit	y	n
Mouth breathing habit, snoring, difficulty in breathing	y	n
Tooth grinding, jaw clenching, jaw clicking or locking	y	n
Do you have or experience any pain in the muscles face or around your ears	y	n
Pain in the jaws or ringing in the ears	y	n
Difficulty encountered in chewing or jaw opening	y	n
History of supernumerary (extra) or congenitally missing teeth	y	n
Have any permanent teeth been removed	y	n
Any teeth irritating cheek, lips, tongue or your palate (roof of mouth)	y	n
Have you ever had orthodontic treatment	y	n
Worn a bite plate or retainer	y	n
Are you under another dentist's care	y	n

Specialist _____

Allergic to latex (gloves)	y	n
Concerned about spaced crooked or protruding teeth	y	n
Aware of over/under developed jaw	y	n
Relatives with similar tooth or jaw issues	y	n
Any wisdom tooth problems	y	n
Have you had a bad dental experiences	y	n

How often do you brush _____

How often do you floss _____

Physician's _____

If there are any changes to my medical or dental status, I will so inform this practice.

Signature of Patient _____ **Date** _____

Signature of Doctor _____ **Date** _____

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The following information is requested so that we can communicate properly with the people involved with your treatment. Please fill in only if applicable. *ALL INFORMATION IS CONFIDENTIAL AND IS TREATED WITH THE UTMOST RESPECT.*

Patient Information

First		**Last**		**E-mail**	
Address				**DOB**	
City		**State**	**Zip:**	**Age**	
Home		**Work**			
SS#		**Employer**			
School		**Work Address**			
Referred By		**Dentist's**			

Family Information

Patient's Spouse

First		**Last**			
Home		**Work**			
Address		**City**		**ST.**	**ZIP**
Spouse's Occupation		**Name of Employer**			

Emergency Contact

First		**Last**			
Home		**Work**			
Address		**City**		**ST.**	**ZIP**

Insurance/Other Information

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charges for care in our office.

	Name of Insured / Name of Employer	Birth Date	Insurance Company Name
Primary			
Secondary			