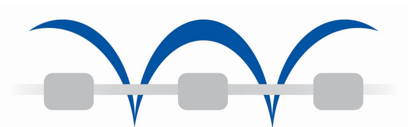

Patient Name ____ Date of Birth ____________

DENTAL HISTORY

YES	NO	Do you have difficulty or pain when opening your mouth?
YES	NO	Do you hear noises in the jaw joints?
YES	NO	Have you ever had an injury to your jaw, head or neck?
YES	NO	Have you previously been treated for temporomandibular disorder (TMD, TMJ)?
YES	NO	Have you ever been treated for periodontal disease?
YES	NO	Have you ever sucked your thumb or fingers? If yes, until what age: ___________
YES	NO	Do you have any speech problems?
YES	NO	Have any teeth been injured or chipped due to an accident?
YES	NO	Have you ever been informed of extra or missing permanent teeth?
YES	NO	Have you had any previous orthodontic consultation or treatment?
YES	NO	Does anyone in the family have a similar dental condition?
YES	NO	Would you mind wearing braces?
YES	NO	Do you have a condition requiring pre-medicating for dental procedures?

Medical History

Do you have or have you had any of the following diseases or medical problems? (Please check (√) all that apply.)

- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Fainting spells
- ☐ Sinus troubles
- ☐ Cardiovascular disease
- ☐ Seizures
- ☐ Kidney problems
- ☐ Stroke
- ☐ Rheumatic heart disease
- ☐ Hepatitis/Jaundice/Liver disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Heart attack
- ☐ Coronary occlusion
- ☐ Diabetes
- ☐ Congenital heart disease
- ☐ Allergy _______________
- ☐ Arteriosclerosis
- ☐ Stomach Ulcers
- ☐ Hay fever
- ☐ Tuberculosis

YES	NO	Are you now under the care of a physician? If yes, what is the condition being treated? ______________________________
YES	NO	Have you been hospitalized or had a serious illness within the past five years? If yes, please explain: ______________________________
YES	NO	Have you had abnormal bleeding associated with previous extractions, surgery or trauma?
YES	NO	Do you have any blood disorder (e.g. HIV, anemia)? If yes, please describe the blood disorder: ______________________________
YES	NO	Do you have any disease, condition or problem not listed above that you think we should know about? If yes, please explain: ______________________________
YES	NO	May we consult with your doctor, dentist or any previous health practitioner who may have knowledge of prior treatment, disease or illness?
YES	NO	If you are a female, are you pregnant?

PLEASE TURN OVER

TOLEDO 3915 Sunforest Court, Toledo, OH 43623 (419) 473-1339
ARCHBOLD 200 West Field Drive, Archbold, OH 43502 (419) 445-9026

SPECIALIST IN ORTHODONTICS FOR CHILDREN & ADULTS

List any medications or substances (i.e.: latex) to which you are allergic: ______________________

List all medications you are currently taking: ______________________

Primary Care Physician: ______________________

Dentist: ______________________

What was the approximate date of your last dental exam? ______________________

Has anyone in your family been treated in our office? ______________________

Who should we thank for referring you to our office? ______________________

Who is financially responsible for this account? ______________________

Reason for consultation and information desired: ______________________

Minor Patient:

Address: __________ City: __________ State: ____ Zip code: ______

Home Telephone: __________ School: __________ Grade: ______

Father's Name: __________ SS# __________ Birth date: __________

Address: __________ City: __________ State: ____ Zip code: ______

Home Telephone: __________ Cell phone: __________

Employer: __________ Occupation: __________ Work Telephone: __________

Orthodontic Insurance? Y N Insurance Company __________

Group Number__________ Policy Number__________ Telephone__________

Mother's Name: __________ SS# __________ Birth date: __________

Address: __________ City: __________ State: ____ Zip code: ______

Home Telephone: __________ Cell phone: __________

Employer: __________ Occupation: __________ Work Telephone: __________

Orthodontic Insurance? Y N Insurance Company __________

Group Number__________ Policy Number__________ Telephone__________

Adult Patient:

Address: __________ City: __________ State: ____ Zip code: ______

Home Telephone: __________ Cell phone: __________

SS#__________ Spouse Name: __________

Employer: __________ Occupation: __________ Work Telephone: __________

Orthodontic Insurance? Y N Insurance Company __________

Group Number__________ Policy Number__________ Telephone__________

Please promptly inform this office of any changes in your medical or dental history.
I authorize the use of this signature on insurance forms and to release information necessary to secure payment.

Signature: ______________________ Date: __________