

PATIENT HISTORY INFORMATION for KARLIN ORTHODONTICS

Patient's Name _____ Nickname _____ Sex _____
Home Address _____ Date of Birth _____
Home Phone _____

Information for patients who are minors:

FATHER

MOTHER

Name _____
Address _____

Name _____
Address _____

Business Phone _____
Cell Phone _____

Business Phone _____
Cell Phone _____

Parent's Marital Status: Married _____ Separated _____ Divorced _____ Widowed _____

Information for adult patients:

Occupation _____ Business Phone _____ Marital Status _____
Name of Spouse _____ Spouse's Business Phone _____
Children's Names and Ages _____

MEDICAL HISTORY

Is the patient experiencing any health problems? Yes ___ No ___ Reason _____
Any major or unusual illnesses? Yes ___ No ___ Explain _____
Currently under physician's care? Yes ___ No ___ Reason _____
Currently taking medication? Yes ___ No ___ List _____
Allergies? Yes ___ No ___ List _____
Drug sensitivity/allergies? Yes ___ No ___ List _____
Patient's Physician: _____ Physician's Phone: _____

Please Check if Patient Has or Had any of the Following:

_____ Heart Murmur _____ Has the patient ever been advised to take antibiotics prior to dental treatment?
_____ Anemia _____ Heart disease _____ Frequent colds or flu
_____ Blood Disease _____ Tuberculosis _____ Mouth breathing
_____ Prolonged bleeding _____ Endocrine Problems _____ Tonsillitis
_____ Diabetes _____ Jaundice _____ Tonsils Removed: Age _____
_____ Hepatitis _____ Bone Disorders _____ Adenoid or Sinus Infections
_____ Rheumatic Fever _____ Asthma _____ Adenoids Removed: Age _____
_____ Herpes _____ Epilepsy/Seizure Disorder _____ AIDS/AIDS Related Complex

Is there any possibility that the patient could be pregnant? _____
Adolescent females only: Has the patient started having menstrual cycles? _____

DENTAL HISTORY

Name of local dentist patient sees for cavity checkups/restorative dentistry _____
What was the date of the patient's last dental cleaning? _____
Has the patient had any severe jaw or facial injuries? _____ Explain _____
Has the patient had any injuries to teeth? _____ Explain _____
Has the patient had a history of thumb or finger sucking? _____ Explain _____
Has the patient consulted an orthodontist previously? _____
Are you satisfied with the prior treatment? _____

Has there ever been a history of:

_____ Clenching Teeth _____ Muscular Soreness around head/neck _____ Jaw Joint Soreness _____ Jaw Popping
_____ Grinding Teeth _____ Excessive Headaches _____ Jaw Joint Clicking _____ Ringing in the ears

Is there any other information that may be helpful? _____
Why are you seeking an orthodontic consultation? (What problems require correction?) _____
How did you hear about our office? _____

Signed _____ Date _____