CELEBRITY ORTHODONTICS

PATIENT INFORMATION

ALL ABOUT YOU

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____

Male: ____ Female: ____ Birthdate: ___/___/___ Age: _____

Single Married Divorced Widowed Separated

SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: ( ) _____ Email: _____

Occupation: _____

Employer: _____ How Long?: _____

Work #: ( ) _____ Ext: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Where/when is the best time to reach you?: _____

Whom may we thank for referring you?: _____

Emergency Contact: _____

Phone: ( ) _____

OTHER CONTACT INFORMATION

His/Her Name: _____

Relation: _____

Employer: _____

Phone #: ( ) _____ Ext: _____

DENTAL HISTORY

General Dentist: _____

Date of Last Exam: _____

What are the main concerns that you would like orthodontics to accomplish?: _____

_____

Have you ever had or been evaluated for orthodontic treatment? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

You current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had an injury to your: mouth / teeth / chin?

Do you have any missing or extra permanent teeth? Yes No

Do you generally breathe through your mouth? Yes No

If yes: While awake? While asleep?

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? Yes No

MEDICAL HISTORY

Your current medical condition is: Good Fair Poor

Are you currently under the care of a physician?

Yes No Please explain: _____

Physician's Name: _____

Are you taking an prescription/over-the-counter drugs? Yes No

Please list each any prescription/over-the-counter drugs? _____

_____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Anemia/Radiation Treatment
Y N Artificial Bones/ Joints/ Valves
Y N Asthma
Y N Arthritis
Y N Blood Transfusion
Y N Cancer/ Chemotherapy
Y N Diabetes
Y N Congenital Heart Defects
Y N Tuberculosis
Y N Difficulty Breathing
Y N Glaucoma
Y N Drug or Alcohol Abuse
Y N Emphysema
Y N Epilepsy/ Seizures/ Fainting
Y N Fever Blisters/ Herpes
Y N Heart Murmer
Y N Heart Surgery/ Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/ Low Blood Pressure
Y N HIV+/ AIDS
Y N Hospitilization
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/ Scarlet Fever
Y N Shingles
Y N Sinus Problems
Y N Severe/ Frequent Headaches
Y N Heart Attack
Y N Ulcers/ Colitis
Y N Venereal Diseases

Are you Pregnant? Yes No

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

Y N Asprin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Metals/Plastics	Y N Other

Please list any other drugs/materials that you are allergic to:

_____

_____

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

_____
Reviewed

we're all about smiles