

MEDICAL/DENTAL HISTORY

Please check of patient has or has had:

- | | |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Joint swelling | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bone disorders | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart trouble or murmur | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatic trouble | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Faintness/Dizziness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emotional problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Brain Injury | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney or Liver problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earaches |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Joint Prosthesis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (<i>Adolescent females</i>) Has menstruation begun? Date: _____ | |

On Items answered "Yes", please provide us with a more detailed description:

Please check Yes or No

- [Y] [N]
- Any injuries to face, mouth, teeth?
- Thumb, finger, or lip sucking?
- More than average amount of decay?
- Any missing permanent teeth?
- Any extra permanent teeth?
- Any teeth removed by extractions?
- Does patient grind or clench teeth?
- Any difficulty in chewing or swallowing?
- Any pain or clicking in jaw joint?
- Does patient visit dentist regularly?
- Has an orthodontist been consulted previously?

Reason:

What would you like orthodontic treatment to accomplish?

List any other serious illnesses: _____

List any allergies: _____

List drugs or medications now being taken: _____

Name of primary physician: _____

EMERGENCY CONTACT INFORMATION:

In cast of emergency, who should we contact? _____ phone# _____

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes even after treatment. I have read and fully understand this paragraph. I have truthfully answered all of the above questions and agree to inform the office of any changes in my medical or dental history. In addition, I authorize Dr. Lindgren to perform a complete orthodontic evaluation.

Signature (parent if patient is a minor) _____ Date _____