Cottonwood Orthodontics, PC

Patient Name _____ Gender: _____ DOB: _____ Age: _____

Medical History

Name of your medical Doctor or Group _____

Phone number _____Date of last medical exam_____

Are you now under the care of a Physician? _____ Explain: _____

_____

Have you had any serious illness or operations? _____Explain: _____

_____

Are you currently taking any medications? _____List _____

_____

Are you allergic to any medication or substance? _____List _____

Please Mark Y, N, or DK/U (Don't Know/Understand)

Y N DK/U Heart Disease/Problems	Y N DK/U Birth Defects	Y N DK/U Kidney Diseases	Y N DK/U AIDS/HIV Positive
Y N DK/U Heart Murmur	Y N DK/U Family medical condition	Y N DK/U Hepatitis/Jaundice/liver	Y N DK/U Tuberculosis
Y N DK/U Rheumatic Fever	Y N DK/U Stroke	Y N DK/U Arthritis	Y N DK/U Emphysema
Y N DK/U High Blood Pressure	Y N DK/U Epilepsy/Seizures/Fainting	Y N DK/U Sinus Trouble/Allergies	Y N DK/U Drug Addiction
Y N DK/U Blood Disorder-Anemia	Y N DK/U Major accidents/Fractures	Y N DK/U Asthma	Y N DK/U Alcoholism
Y N DK/U Thyroid Disease	Y N DK/U Tumor/Growth	Y N DK/U Psychiatric Treatment	Y N DK/U Smoke
Y N DK/U Diabetes	Y N DK/U Radiation Treatment	Y N DK/U Blood Transfusion	Y N DK/U Pregnant/planning

Do you have any disease, or condition not listed above that we should know about? _____Explain: _____

_____

DENTAL HISTORY

Dentist Name: _____Date of last Dental exam? _____

X-rays last taken? _____ Date of last Dental Cleaning? _____ Dental work needed? _____

Do your gums bleed, feel tender or hurt? _____ Have you ever been treated for Gum Disease? _____

Any Major Falls, Accidents, or Operations affecting the face or teeth? _____ Explain: _____

_____

Any clicking noises, pain, or limitations when opening/closing your mouth? _____

Jaw Locking/limited opening_____ Do you get headaches? _____ Frequency? _____

Do you have any of the following habits? Thumb-sucking/Pacifier_____ Mouth Breathing_____ Snoring _____Lip Biting_____

Grinding_____ Tongue thrusting_____Other_____Explain:_____

What is your main Reason(s)for this visit? _____

_____

Do you want to change the appearance of your: Teeth _____ Lips_____ Chin/Jaw_____ Other_____

Do you feel the appearance of your mouth/teeth affects your: Self Image/Esteem _____ Interactions with others _____Speech _____

Do you have difficulty chewing your food? _____Explain:_____

How do feel about wearing braces? _____ Would you prefer Metal or Clear Braces? _____

Have you ever had previous Orthodontic Treatment?_____ When? _____ By Whom? _____

For how long? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. I hereby consent to the initial examination, including the taking of diagnostic radiographs (X-rays), photographs, and casts as deem necessary by Cottonwood Orthodontics, PC.

Signature (Patient/ Parent/Guardian)_____Date:_____

Signature (Dental staff member)_____ Date:_____