MEDICAL HISTORY

YES NO

- ☐ ☐ HAS PATIENT HAD A PHYSICAL EXAM DURING THE PAST YEAR?
- ☐ ☐ IS PATIENT CURRENTLY UNDER A PHYSICIAN'S CARE?
- ☐ ☐ HAS PATIENT HAD MAJOR SURGERY?
- ☐ ☐ IS PATIENT TAKING ANY PILLS, MEDICATIONS, OR DRUGS?
- ☐ ☐ IS PATIENT ALLERGIC TO NOVOCAINE OR PENICILLIN?
- ☐ ☐ HAS PATIENT HAD ANY UNUSUAL REACTION TO ANY MEDICATION?
- ☐ ☐ HAS PATIENT HAD TONSILS AND/OR ADENOIDS REMOVED?
- ☐ ☐ DOES PATIENT HAVE FAINTING OR DIZZY SPELLS?
- ☐ ☐ DOES PATIENT HAVE TOO HIGH OR LOW BLOOD PRESSURE?

HAS PATIENT BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING?

YES	NO		YES	NO	
☐	☐	HEART PROBLEMS	☐	☐	HEPATITIS / HIV
☐	☐	KIDNEY PROBLEMS	☐	☐	RHEUMATIC FEVER
☐	☐	LUNG PROBLEMS	☐	☐	EMOTIONAL PROBLEMS
☐	☐	LIVER PROBLEMS	☐	☐	MALIGNANCIES
☐	☐	ALLERGIES / LATEX	☐	☐	ENDOCRINE PROBLEMS
☐	☐	DIABETES	☐	☐	BONE
☐	☐	EPILEPSY	☐	☐	PROLONGED BLEEDING
☐	☐	ARTHRITIS	☐	☐	TUBERCULOSIS
☐	☐	ANEMIA	☐	☐	ASTHMA

YES NO

☐ ☐ ARE THERE ANY OTHER MEDICAL PROBLEMS I SHOULD BE AWARE OF?

_____

PHYSICIAN _____

DATE OF LAST VISIT

DENTAL HISTORY

WHAT IS THE MAJOR CONCERN ABOUT HE PATIENT'S TEETH?

_____

_____

YES NO

- ☐ ☐ HAS PATIENT HAD PREVIOUS ORTHODONTIC CONSULTATION ?
- ☐ ☐ HAS PATIENT HAD PREVIOUS ORTHODONTIC TREATMENT?
- ☐ ☐ HAS PATIENT BEEN INFORMED OF AND EXTRA OR MISSING TEETH?
- ☐ ☐ HAVE ANY PERMANENT TEETH BEEN REMOVED BY EXTRACTION?
- ☐ ☐ HAS ANY FAMILY MEMBER HAD ORTHODONTIC TREATMENT?
- ☐ ☐ WHO? _____
- ☐ ☐ DOES PATIENT NOW SUCK HIS/HER THUMB?
- ☐ ☐ DOES PATIENT HAVE ANY SPEECH PROBLEMS?
- ☐ ☐ DOES PATIENT GRIND OR CLENCH HIS/HER TEETH?
- ☐ ☐ DOES PATIENT HAVE PAIN OR CLICKING OF THE JAW JOINT?
- ☐ ☐ HAVE ANY TEETH BEEN INJURED OR CHIPPED DUE TO AN ACCIDENT?
- ☐ ☐ HAS PATIENT EVER HAD PAIN IN THE FACE OR JAW
- ☐ ☐ HAS PATIENT EVER HAD SEVERE HEAD OR JAW INJURY?
- ☐ ☐ DO PATIENT'S GUMS BLEED ON BRUSHING OR FLOSSING?
- ☐ ☐ IS PATIENT CONCERNED ABOUT APPEARANCE OF HIS/HER TEETH?
- ☐ ☐ DOES PATIENT WANT HIS/HER TEETH STRAIGHTENED?
- ☐ ☐ ARE THERE ANY OTHER DENTAL/ORTHODONTIC PROBLEMS I SHOULD BE AWARE OF? _____

_____

DENTIST _____

DATE OF LAST VISIT

DATE _____

PT # _____

PATIENT'S LAST NAME _____ FIRST _____ MIDDLE _____ NICKNAME _____

☐ MALE ☐ FEMALE

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____ BIRTH DATE _____

HOME PHONE _____ PATIENT'S CELL PHONE _____ SCHOOL _____ GRADE _____

FATHER'S LAST NAME _____ FIRST _____ MIDDLE _____ EMAIL _____

HOME ADDRESS (if different than patient) _____ CITY _____ STATE _____ ZIP _____ CELL PHONE _____ WORK PHONE _____

OCCUPATION _____ EMPLOYER _____ DENTAL INSURANCE *(please circle)* YES NO MARITAL STATUS *(please circle)* S M D R W

MOTHER'S LAST NAME _____ FIRST _____ MIDDLE _____ EMAIL _____

HOME ADDRESS (if different than patient) _____ CITY _____ STATE _____ ZIP _____ CELL PHONE _____ WORK PHONE _____

OCCUPATION _____ EMPLOYER _____ DENTAL INSURANCE *(please circle)* YES NO MARITAL STATUS *(please circle)* S M D R W

WHO MAY WE THANK FOR REFERRING YOU _____

PERSON(S) RESPONSIBLE FOR ACCOUNT _____

I acknowledge I have received a copy of the DENTAL NOTICE OF PRIVACY PRACTICES from the office of Drs. Constant and Contro.

PARENT / GUARDIAN SIGNATURE _____ DATE _____

DAVID T. CONSTANT, DDS
CURTIS CONTRO, DDS, MS