cari orthodontics

KENNETT · MEDIA

ADULT

Today's Date _____

Patient Name _____

Address _____

City, State, Zip _____

Home Phone_____ Birthdate _____ Age _____ Sex _____

Email _____

Employer _____

Work Phone _____ Cell Phone _____

Responsible Party/Relationship _____

Family Dentist _____ Family Physician _____

What are your smile concerns? _____

_____

Who may we thank for referring you to our office? _____

Have you ever had an orthodontic evaluation? Yes _____ No _____

If yes, when and by whom? _____

Spouse Information:

Name _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Employer _____

Person responsible for account:

Name _____

Address _____

City, State, Zip _____

PLEASE CONTINUE ON OPPOSITE SIDE

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Medical Health History:

Do you have or have you had any of the following oral conditions? Check all that apply.

☐ Sensitive Teeth	☐ Bleeding Gums	☐ Food Wedging between Teeth
☐ Clenching or Grinding	☐ Pain around Ear	☐ Swelling or Lumps in the Mouth
☐ Bad Breath	☐ Mouth Breathing	☐ Tobacco Use
☐ Pain in the Jaw or Face	☐ Oral Habits	☐ Jaw Joint Sounds or Pain
☐ Dry Mouth	☐ Pain when Opening Mouth	☐ Inability to Floss between Teeth
☐ Poorly Functioning Teeth	☐ Discolored Teeth	☐ Jaw gets Stuck Open or Closed

Have you ever had any of the following medical problems?

Y/N	Y/N	Y/N
☐ ☐ Rheumatic Fever	☐ ☐ Congenital Heart Murmurs	☐ ☐ Heart Condition
☐ ☐ Diabetes	☐ ☐ Anemia	☐ ☐ Arthritis or Swollen Joints
☐ ☐ Inflammatory Rheumatism	☐ ☐ Kidney Problems	☐ ☐ Tuberculosis
☐ ☐ Asthma	☐ ☐ Jaundice	☐ ☐ Hepatitis Type _____
☐ ☐ Liver Disease	☐ ☐ High Blood Pressure	☐ ☐ Low Blood Pressure
☐ ☐ Severe Headache	☐ ☐ Dizziness or Fainting	☐ ☐ Convulsions or Seizures
☐ ☐ Eye Problems	☐ ☐ Ear Problems	☐ ☐ Sinus Problems
☐ ☐ Nose Bleeds	☐ ☐ Speech Problems	☐ ☐ Swallowing Problems
☐ ☐ Easy Bruising	☐ ☐ HIV/AIDS	☐ ☐ ADD/ADHD

Y/N

☐ ☐ Is patient currently under the care of a physician? If yes, describe _____

☐ ☐ Has patient ever been hospitalized or had any serious illness? If yes, describe _____

☐ ☐ Does patient have any drug allergies? If yes, list _____

☐ ☐ Is patient allergic to latex, metal or vinyl? If yes, list _____

☐ ☐ Is patient taking any medication? If yes, list _____

☐ ☐ Female patients - Could patient possibly be pregnant at the present time?

Onset of menarchy (to determine amount of growth remaining) _____

I certify that I have read and understand these questions and that the information given is accurate. I understand the importance of a truthful health history and that my orthodontist and his staff will rely on this information for treating me. I will not hold my orthodontist, or any other member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient or Parent Signature (if patient is under 18)

_____ Date _____