



MEDICAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING

<input type="checkbox"/> JOINT SWELLING	<input type="checkbox"/> TUBERCULOUS
<input type="checkbox"/> BONE DISORDERS	<input type="checkbox"/> ANEMIA
<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> EPLIEPSY (CONVULSIONS)
<input type="checkbox"/> MITRAL VALVE TROUBLE	<input type="checkbox"/> PROLONGED BLEEDING
<input type="checkbox"/> RHEUMATIC TROUBLE	<input type="checkbox"/> FAINTNESS
	<input type="checkbox"/> DIZZINESS
<input type="checkbox"/> DIABETES	<input type="checkbox"/> TONSILS REMOVED
<input type="checkbox"/> EMOTIONAL PROBLEMS	<input type="checkbox"/> ADENOIDS REMOVED
<input type="checkbox"/> BRAIN INJURY	<input type="checkbox"/> SORE THROAT
<input type="checkbox"/> KIDNEY/LIVER INVOLVEMENT	<input type="checkbox"/> TONSILITIS
<input type="checkbox"/> JOINT PROSTHESIS	<input type="checkbox"/> EARACHES
<input type="checkbox"/> LATEX ALLERGY	<input type="checkbox"/> METAL/PLASTIC ALLERGY

HAVE YOU OR ANY MEMBERS OF YOU FAMILY HAD:
 (Y) (N) RHEUMATOID ARTHRISTIS
 (Y) (N) LUPUS

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION:
 : _____

DENTAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

ANY INJURIES TO FACE, MOUTH, OR TEETH
 THUMB, FINGER, SUCKING
 MORE THAN AVERAGE AMOUNT OF TOOTH DECAY
 EXTRA PERMANENT TEETH
 TEETH REMOVED BY EXTRACTION
 DIFFICULTY IN SWALLOWING OR CHEWING
 ANY PAIN OR CLICKING WHEN OPENING MOUTH
 IS PATIENT ADOPTED? AT WHAT AGE? _____
 PREVIOUSLY CONSULTED BY ANOTHER ORTHODONTIST

(Y) (N) DOES THE PATIENT VISIT THE DENTIST REGULARLY?
 DATE OF LAST VISIT _____

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION:
 : _____

IS PATIENT PRESENTLY UNDER PHYSICIAN CARE FOR ANY REASON?

NAME OF PRIMARY PHYSICIAN _____

LIST ANY OTHER SERIOUS ILLNESSES

LIST DRUGS OR MEDICATIONS BEING TAKEN: _____

DO YOU TAK ANY MEDICATIONS FOR OESTEOPOROSIS?
 IF YES, PLEASE LIST: _____

LIST ANY ALLERGIES: _____

WE ARE UNABLE TO ACCEPT DIVORCE DECREES AS ASSIGNMENTS OF RESPONSIBILITY FOR A CHILD'S ORTHODONTIC BILLS. THE PARENT ACCOMPANYING THE CHILD SHOULD PAY FOR THE SEVICES AND SEED ANY REIMBURSEMENT FOR THE OTHER PARENT. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I GIVE MY PERMISSION FOR ANY PHOTOGRAPHS, X-RAYS, OR STUDY MODELS TO BE USED FOR THE DISPLAYS AT SCIENTIFIC MEETINGS, PRESENTATION, AND PUBLICATION OF A SCIENTIFIC NATURE OR FOR STUDY GROUP PURPOSES TO FURTHER THE ART AND SCIENCE OF ORTHODONTICS. I, THE UNDERSIGNED, AGREE TO PAY FOR ATTORNEY FEES AND TOEHR COSTS OF COLLECTIONS IN THE EVENT IT BECOMES NECESSARY TO USE ATTORNEY SERVICES TO SECURE PAYMENT OF THIS ACCOUNT.

Signature: _____ Date: _____