

Northern Dental Specialists



Adult

Getting to Know You:

DATE _____

PATIENTS NAME: _____ Prefer to be called: _____
Age: _____ Birthdate: _____ SSN: _____
Address: _____ City & Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Occupation: _____ Employer: _____
Address: _____ Phone: _____
Spouses Name: _____
Employer: _____ Occupation: _____ SSN: _____
Cell Phone: _____ Work Phone: _____
Hobbies/Interests: _____
Children and ages: _____
Other family members treated here: _____

Do you anticipate a move or transfer in the next 6-12 months? Yes No
Does the patient have orthodontic insurance? Yes No

Whom may we thank for referring you to us? _____
How have you heard about our office (check all that apply)?
___ Friend/Family (Name(s) _____)
___ Your Dentist _____ Charity Event (Event name: _____)
___ Advertisement _____ Other _____

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____
Address: _____ Phone: _____

Have you had any of the following?	Are you aware of any of the following problems?
Previous orthodontic exam or treatment . . . Yes No	Clicking, popping or grating noise in your jaw joints? . . . Yes No
Extractions (teeth removed)? Yes No	If yes, is there discomfort with it? Yes No
Periodontal (gum) therapy? Yes No	Clenching or grinding of your teeth? Yes No
Endodontic (root canal) therapy? Yes No	Sores, lumps or irritated areas in your mouth? Yes No
TMJ (jaw joint) problems or therapy? Yes No	Food catching or collecting between your teeth? Yes No
Frequent toothaches or sensitive teeth? Yes No	Numbness or pain in your mouth, jaw joints, or face? Yes No
History of mouth breathing, finger or thumb sucking, nail biting? Yes No	
History of injury to face, head or teeth? Yes No	
Have tonsils and adenoids been removed? _____ Date: _____	
Would you mind wearing "braces" if necessary? Yes No	

Describe the orthodontic problem in your own words (what are YOUR main concerns?) _____

Who noticed the problem? Patient _____ Dentist _____
Any additional comments, questions, or suggestions: _____

Medical History

Patient's physician(s) _____ Date last seen _____

Address _____ Phone _____

1. Please circle your PRESENT HEALTH: excellent good fair poor
2. Has your health CHANGED in the last year? Yes No
3. Have you been HOSPITALIZED in the last 5 years? Yes No
4. Has a doctor TREATED or EXAMINED you for any condition in the last 3 years? Yes No
5. Are you ALLERGIC to any drugs or other substances? Yes No
6. Are you required to restrict your work or activities? Yes No
7. Is your diet restricted or specially prescribed? Yes No
8. Are you taking ANY MEDICATIONS regularly (even aspirin or antacids)? Yes No
- If "Yes", please list them with dosages: _____

PLEASE CIRCLE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM.

- | | | |
|---|---|---|
| 1. Heart trouble or murmur Yes No | 17. Bronchitis Yes No | 34. Sinus trouble Yes No |
| 2. Rheumatic fever Yes No | 18. Frequent colds/
sore throat Yes No | 35. Artificial joints or valves Yes No |
| 3. Heart surgery Yes No | 19. Emphysema Yes No | 36. Venereal disease Yes No |
| 4. Heart attack Yes No | 20. Birth Defects Yes No | 37. Thyroid/parathyroid
disorders Yes No |
| 5. High blood pressure Yes No | 21. Scarlet fever Yes No | 38. Cancer or tumors Yes No |
| 6. Low blood pressure Yes No | 22. Hives/rash Yes No | 39. Tuberculosis Yes No |
| 7. Chest pains Yes No | 23. Recurrent illness Yes No | 40. Speech impairment or
therapy Yes No |
| 8. Stroke Yes No | 24. Diabetes Yes No | 41. Hearing problem Yes No |
| 9. Immune system
problems, AIDS Yes No | 25. Kidney disease Yes No | 42. Emotional or
nervous problems Yes No |
| 10. Blood transfusion Yes No | 26. Liver disease Yes No | 43. Frequent headaches Yes No |
| 11. Excessive or
prolonged bleeding Yes No | 27. Epilepsy/seizures Yes No | 44. Smoker Yes No |
| 12. Blood disorder Yes No | 28. Fainting/dizzy spells Yes No | 45. Nervous/anxious Yes No |
| 13. Shortness of breath Yes No | 29. Ulcers Yes No | 46. Recent unintentional
weight changes Yes No |
| 14. Persistent cough Yes No | 30. Arthritis Yes No | 47. Psychiatric care Yes No |
| 15. Asthma/hay fever Yes No | 31. Glaucoma Yes No | |
| 16. Lung disease Yes No | 32. Allergies Yes No | |
| | 33. Ear pains or infections Yes No | |

IF FEMALE, ARE YOU:

Pregnant/Nursing Yes No On Birth Control Pills Yes No

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

COMMENTS: _____

1. _____ Date _____
Signature of Parent or Guardian

2. _____ Date _____
Signature of Parent or Guardian

3. _____ Date _____
Signature of Parent or Guardian

4. _____ Date _____
Signature of Parent or Guardian

5. _____ Date _____
Signature of Parent or Guardian

6. _____ Date _____
Signature of Parent or Guardian