MEDICAL / DENTAL HISTORY FORM

Patient Name: ______________________________
Address: ______________________________

Date of Birth: ______________________________

Billing Party Name: ______________________________
Address: ______________________________

Relationship to Patient: ______________________

General Dentist/Clinic Name: ______________________
Date of last cleaning: ______________________________

Main Concern: ______________________________

How did you learn of Three Rivers Orthodontics?
(Please Circle One)
Dentist Family Insurance Location Web Friend
Other________________

Have you seen an orthodontist or had braces? Yes / No
If yes, when__________________________________

Have we treated any other family members? Yes / No
If yes, who? __________________________________

Past and Current Medical / Dental Conditions

Has the patient been diagnosed or treated for any of the following medical conditions?
(Circle all that apply)

Heart Disease/Defect High or Low Blood Pressure Asthma Cancer Arthritis Diabetes
Tuberculosis Epilepsy/Seizures AIDS/HIV positive Hepatitis Osteoporosis
Eating Disorder Depression/Anxiety Bleeding Disorder Bisphosphonate Therapy Other: ________________

Allergies to:
Latex: Yes / No Metals: Yes/No
Hay Fever/Air Borne: ____________________
Medications/Other ____________________
Antibiotics required prior to dental visits? Yes / No
Reason: ______________________________

Does patient have a persistent thumb or finger habit?
Yes / No

Current Medications (Prescription, over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY

Has the patient been diagnosed or treated for any of the following dental conditions?
(Circle all that apply)

Grinding/Clenching Jaw Injuries/Surgery Jaw Joint Pain/Popping Missing Teeth Extra Teeth Frequent Headaches
Gum Disease Root Canal Therapy Teeth Sensitivity Broken Teeth Dental Implants

Any other disease, conditions or heath problem we should be aware of ? ______________________________

RELEASE AND WAIVER

Do you consent to appointment reminder postcards? Yes / No

I authorize release of any information regarding mine or my child's orthodontic treatment to my dental and / or medical insurance company.

Patient / Parent / Guardian Signature ______________________________ Date____________________

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in mine or my child's medical or dental health.

Patient / Parent / Guardian Signature ______________________________ Date____________________