HEALTH HISTORY / PATIENT INFORMATION FOR ERICKSON ORTHODONTICS

Patient's Name_____ DOB_____ AGE_____

Nick Name_____ Male_____ Female_____

Complete Address_____

Best telephone number to reach you at_____

Primary E- Mail_____

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

Main concern for orthodontic treatment:_____

If a Minor: Father's Name_____ Mother's Name_____

Father's Phone_____ Mother's Phone_____

Financially Responsible Party Information:

Responsible Party Name_____

Home #_____ Cell #_____ Work#_____

Social Security #_____ Date of Birth_____

Primary DENTAL Insurance Information

Company Name_____

Address_____

Phone #_____ Employer (if applicable)_____

Subscriber Name_____

Subcriber I.D._____ Subscriber DOB_____

DO YOU HAVE SECONDARY COVERAGE _____NO _____YES (If yes, please include info on bottom of pg 2)

Dentists's Name_____ Last cleaning/check up_____

Now or in the past has the patient: (Please circle Y for Yes or N for No)

Y N Permanent or "extra" teeth removed?

Y N History of speech problems?

Y N Mouth breathing habit, snoring, difficulty breathing?

Y N Teeth sentsitive to hot or cold; teeth throb or ache?

Y N Bleeding gums, bad taste or mouth odor?

Y N Difficulty when chewing or jaw opening?

Y N Food impaction between teeth?

Y N Tooth grinding or jaw clinching?

Y N Jaw fractures, cysts or mouth infections?

Y N Abnormal swallowing habit (tongue thrusting)

Y N Any pain in jaw or ringing in ears?

Y N "Dead teeth" or root canals treated?

Y N Any pain or soreness in the muscles of the face or around the ears?

Y N Difficulty when chewing or jaw opening?

Y N Aware of loose, broken or missing fillings?

Y N Any teeth irritating cheek, lip, tongue or palate?

Y N Aware of under or over developed lower jaw?

Y N Taking any forms of fluoride?

Y N Had periodontal (gum) treatment?

Y N Concerned about spaced, crooked or protruding teeth?

Y N Frequent canker sores or cold sores?

Y N Any relative with similar tooth or jaw relationship?

Y N Any serious trouble assoc. w/any previous dental treatment?

Y N Would you object to wearing orthodontic appliances (braces) if they are recommended?

Y N Ever had a prior orthodontic examiniation or treatment?

NOW OR IN THE PAST HAS THE PATIENT HAD:

Y N Birth defects or hereditary problems?

Y N Bone fractures, or major accidents?

Y N Endocrine or thyroid problems?

Y N Kidney problems?

Y N Diabetes?

Y N Cancer, tumor, radiation treatment or chemo?

Y N Stomach ulcer or hyperactivity?

Y N Polio, mononucleosis, tuberculoses, Pneumonia?

Y N Problems of the immune system?

Y N AIDS or HIV positive?

Y N Hepatits, jaundice or liver problems?

Y N Fainting spells, seizures, epilepsy or Neurological problems?

Y N Mental health disturbance or depression?

Y N Vision, hearing, tasting or speech difficulties?

Y N Loss of weight recently, poor appetite?

Y N History of eating disorder (anorexia, bulimia)?

Y N Excessive bleeding, anemia or bleeding disorder?

Y N High or low blood pressure?

Y N Skin disorder?

Y N Easily tired?

Y N Chest pain, shortness of breath, ankle swelling?

Y N Does the patient eat a well balanced diet?

Y N Frequent head aches, colds or sore throats?

Y N Ear, nose & throat condition?

Y N Hay fever, asthma, sinus trouble or hives?

Y N Tonsil or adenoid condition?

ALLERGIES OR REACTION TO ANY OF THE FOLLOWING:

Y N Foods (specify)_____

Y N Sulfa Drugs Y N Acrylic

Y N Ibuprofen (Motrin, Advi.)

Y N Animals

Y N Vinyl

Y N Local anesthesia (Novacain, Lidocain)?

Y N Aspirin

Y N Penicillin or other antibiotics_____

Y N Codeine or other narcotics_____

Y N Metals (jewelry, clothing snaps)?

Y N Cardiovascular problems (heart trouble, heart attack, angina, coronary heart defects, heart murmer or rheumatic hear disease)?

FEMALES ONLY: Y N Pregnant Y N Birth control Y N Nursing

I have read and understand the above questions. I will not hold my orthodontist or any memeber of his or her staff responsible for any errors or omissions that I have made in the completion of this form. IF there are any changes later to this history record mediical/dental status, I will so inform this practice.

Signed:_____ Date:_____

Medical History Update or Changes (please date and sign and changes)