ASHMORE ORTHODONTICS MEDICAL AND DENTAL HISTORY

PATIENT'S NAME ___________________________ TODAY'S DATE ____________________

PATIENT'S DENTIST ___________________________ PATIENT'S AGE_______ SEX (assigned at birth)_______

GENDER IDENTITY ___________

The following information is essential for our office to provide orthodontic care in a manner that is compatible with the patient's general health. Your cooperation in providing accurate information is necessary to meet your orthodontic needs safely and efficiently. Incorrect or incomplete information can be dangerous to your health. If you answer YES to any question please provide an explanation.

How would you describe the patient's general health? Good ____ Fair ____ Poor ____

Has the patient been admitted to the hospital in the past 2 years? Yes ____ No ____

If YES, what for and what were the approximate dates? ____

Does the patient have any medical, or behavioral problems we should know about? Yes ____ No ____

If YES, please explain ____

Does the patient use any medications, supplements, or recreational drugs? Yes ____ No ____

If YES, please list and explain what it is for ____

Does the patient vape, smoke or use any tobacco or nicotine products ? Yes ____ No ____

If YES , please explain ____

Is the patient allergic to any medications? Yes ____ No ____

If YES, please list ____

Has the patient ever had excessive bleeding requiring special treatment? Yes ____ No ____

FEMALES UNDER age 18: Has she started menstruation? Yes ____ No ____ If YES, when? ______________

MALES UNDER age 18: Has his voice changed? Yes ____ No ____

Does the patient have OR has the patient EVER had (a): (Please circle if YES)

Heart problem	Nervous disorder	Psychiatric treatment	Kidney disease
Heart attack	Tumor or Growth	Cancer	Glaucoma
Heart murmur	Bone disorder	Tuberculosis	Thyroid problem
Stroke	Arthritis	Ulcer	Diabetes/Hypoglycemia
High Blood Pressure	Asthma	Jaundice	Anemia
Rheumatic Fever	Allergies	Epilepsy	Convulsions / seizures
Endocrine problems	Fainting/ dizziness	Hepatitis A , B, or C	Venereal disease
Radiation Treatment	Osteopenia	Osteoporosis	HIV (AIDS)
Liver disease	Attention disorder	Sleep Apnea	Joint replacement
Tonsilectomy	Adenoidectomy	Persistent ear infections	Acid Reflux

MEDICAL AND DENTAL HISTORY CONTINUED (Page 2)

PATIENT'S NAME ________________________ TODAY'S DATE_______________

Is the patient pregnant? Yes ____ No ____

Does the patient snore? Yes ____ No ____ If YES, how often and how loudly? _____________________________

Is the patient able to breathe through the nose? Yes ____ No ____

Does the patient have any finger or thumb sucking habits? Yes ____ No ____

Does the patient have any speech problems? Yes ____ No ____

Have there been any injuries to the face or teeth? Yes ____ No ____

If YES, please explain ____

Does the patient currently have any dental pain? Yes ____ No ____

Is there any area of the patient's mouth that is sensitive to hot, cold, or pressure? Yes ____ No ____

Does the patient clench teeth? Yes ____ No ____ If YES, when and how often? __________________________

Does the patient grind their teeth? Yes ____ No ____ If YES, when and how often? __________________________

Do the patients gums bleed when they brush? Yes ____ No ____

How often does the patient floss? __________________________

Has the patient been informed of any missing or extra permanent teeth? Yes ____ No ____

Does the patient have any disease, condition, or problem not listed on this form? Yes ____ No ____

If YES, please explain ____

Has the patient had a consultation with an orthodontist previously? Yes ____ No ____

What is the reason the patient is seeking orthodontic treatment? ____

____

How does the patient feel about having orthodontic treatment? ____

Please report any change in health status immediately

To the best of my knowledge, the above questions have been answered correctly. I grant permission for my information to be released to co-treating health practitioners for purposes of orthodontic care and to third party payors for purposes of filing claims on behalf of the patient.

Person completing the form: Print name ________________________ Relationship to patient ___________________

Signature: ____

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.