PureSmile Orthodontics & Dentistry

Patient Information

Date _____

Patient's Last Name (姓) _____ First _____ Middle _____

Date of Birth (month/day/year) _____ Sex _____

Employer _____ Position _____

How did you hear about us? _____

Contact Information (For patients under 18 years of age, please list parent or guardian's contact information)

Email _____ Mobile Phone _____

Home Phone _____ Business Phone _____

Address _____ Postal Code _____

Secondary contact: Name _____ Phone _____

For Patients Under 18 Years of Age

Mother's Name _____ Father's Name _____

School _____ Grade _____

Names and Ages of Siblings _____

Preliminary Health Information

Date of last teeth cleaning _____ Date of last dental X-ray _____

What is your present dental/orthodontic problem or interest? _____

Circle the appropriate answer. If "Yes", please explain.

Do you have any allergies? Yes / No _____

Are you taking any drugs, medications, over-the-counter medicines (including Aspirin), or natural remedies?

Yes / No _____

For women: Are you or could you be pregnant or nursing? _____

CONSENT: The above information is true to the best of my knowledge. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the patient named above and further authorize and consent that the doctor choose and employ such assistance as s/he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that no treatments are rendered unless financial arrangements have been made.

Patient's/Parent's Signature _____ Date _____

For the following questions circle **yes, no, or don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT'S MEDICAL HISTORY

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
yes no dk/u Problems of immune system?
yes no dk/u Hepatitis, jaundice or liver problems?
yes no dk/u AIDS or HIV positive?
yes no dk/u Sexually transmitted disease?
yes no dk/u Fainting spells, seizures, epilepsy or neurologic disease?
yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Easily tired?
yes no dk/u Chest pain, shortness or breath or swelling ankles?
yes no dk/u Cardiovascular problems (heart trouble, heart attack, angins, coronary insufficiency, arterlosclerosis, stroke, inborn heart defects or rheumatic heart?
yes no dk/u Skin disorder?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Allergies or drug reactions?
yes no dk/u Are you taking medication, nutrient supplements or non prescription medicine? Please name them.

_____

yes no dk/u Do you currently have or ever had a substance abuse problem?
yes no dk/u Operation?
yes no dk/u Hospitalized? For? _____
yes no dk/u Other physical problems or symptoms?
yes no dk/u Being treated by another health care
yes no dk/u Professional? For? _____
yes no dk/u Are you in good health? Date most recent physical exam? _____

Female Patient Only

yes no dk/u Are you pregnant?
yes no dk/u Are you taking birth control pills?
yes no dk/u Are you anticipating becoming pregnant?

PATIENT'S DENTAL HISTORY

yes no dk/u Chipped or otherwise injured permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u "Dead Teeth", root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u "Gum Boils", frequent canker sores, cold sores?
yes no dk/u Thumb, finger, sucking habit? Until?
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Do you experience any pain or soreness in the muscles of your face, or around the ears?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)
yes no dk/u Difficulty encountered in chewing or jaw opening?
yes no dk/u History of supernumerary (extra) or congenitally missing teeth?
yes no dk/u Have any permanent teeth been removed?
yes no dk/u Aware of loose broken or missing restorations (fillings)?
yes no dk/u Any teeth irritating cheek, lip, tongue, palate?
yes no dk/u Have you ever had orthodontic treatment or worn a "retainer" or "bite plate"?
yes no dk/u Have you recently been under another dentist's care? Specialist: _____
yes no dk/u Have you ever had periodontal (gum) treatment?
yes no dk/u Concerned about spaced, crooked, protruding teeth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Any relative with similar tooth or jaw relationships?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Have you had any serious trouble associated with any previous dental treatment?

Patient Under 18 Years of Age Only

yes no dk/u Started teething very early or late?
yes no dk/u Primary (baby) teeth removed that were not loose?
yes no dk/u Onset of puberty (approximate date)? _____
yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
yes no dk/u Does patient follow directions?
yes no dk/u Does patient brush his/her teeth conscientiously?
yes no dk/u Does patient have learning disabilities or need extra help with instructions?
yes no dk/u Is patient sensitive, self-conscious?

How often do you brush? _____ Floss? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____

I have read and understand the above questions. I will not hold my orthodontists or any member of his/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 or medical/dental status I will so inform this practice.

_____

Signature of Patient/Guardian Date

Medical History Update or Changes: Date: Comments: Signature:

_____

_____