Orthodontic Information Form

Dan D. Banh, DDS, MS, Inc.

Date_____

Patient's Name_____ SS#_____

Last First Middle

Address_____

Street City State Zip Code

Home Phone_____Cell Phone_____ Birthdate_____ Age_____ Sex_____

If patient is a minor, give patient's or guardian's name_____

How did you hear about our office?_____

Medical History

Physician's Name_____

Is patient in good health?.....Yes___ No___

Does patient have history of major illness?.....Yes___ No___

Is patient currently under the care of a physician for illness?.....Yes___ No___

If yes, explain:_____

Do you have, or have you had any of the following:

	YES	NO		YES	NO		YES	NO
Heart murmur….....	( )	( )	Cerebral Palsy……..(	)	( )	Emphysema……..(	)	( )
High Blood Pressure…...(	)	( )	Epilepsy or Seizures.(	)	( )	Diabetes……...(	)	( )
Radiation Therapy……...(	)	( )	Heart Ailments…….(	)	( )	Liver Disease……(	)	( )
Rheumatic Fever……..(	)	( )	Hepatitis or Jaundice(	)	( )	Kidney Disease…….(	)	( )
Tuberculosis…….....	( )	( )	Chemotherapy……..(	)	( )	Drug Addiction…….(	)	( )
Nervous Disorders……...(	)	( )	Artificial Prosthesis..(	)	( )	HIV……...(	)	( )
Thyroid Disease……...(	)	( )	Anemia……(	)	( )	AIDS…….....	( )	( )
Excessive Bleeding…..…(	)	( )	Glaucoma……(	)	( )	Asthma……..(	)	( )
Respiratory Disease…….(	)	( )	Arthritis……(	)	( )	Stroke……(	)	( )
Mental Disorder……...(	)	( )	Osteoporosis…….....	( )	( )	Other……(	)	( )

Do you have any disease, condition, or problem not listed that you think we should know about?Yes__ No___

If so what? _____

Do you use tobacco in any form?If yes, how much per day _____

Are you taking any medicine? Yes____ No____ If so, what kind?_____

Are you allergic to any drugs? Penicillin ( ) Latex ( ) Nickel ( ) Other:_____

For female, menstrual cycle:……..Yes____ No____ When _____

For Adults, are you currently taking Bisposphinates for osteoporosis?..... Yes____ No____

Dental History

Dentist's name: _____

Have you had any injuries to the face, mouth, or teeth?.....Yes____ No____

If yes, please explain:_____

Do you have difficulty:Chewing?_____ Swallowing?_____ Breathing?_____ Speech Problems?_____

Have you had any previous orthodontic treatment?..... Yes____ No____

Have you been informed of any missing of extra permanent teeth?..... Yes____ No____

Any pain or tenderness in or near your ears?..... Yes____ No____ If yes, Right? ____ Left?_____

Any clicking or discomfort of the jaw joint?..... Yes____ No____ If yes, Right?____ Left?____

Habits: Thumb or Finger sucking……Yes____ No____

Mouth Breathing……..Yes____ No____

Nail/Lip Biting…… Yes____ No____

Grinding or Clenching of teeth…… Yes____ No____

Primary reason for seeking orthodontic treatment:_____

_____

I understand that information that I have given is correct to the best of my knowledge and that it will be held if the strictest of confidence. If there are any changes later in my medical or dental status, I will inform the practice.

_____

Signature Date