ADULT PATIENT INFORMATION

Date _____

Patient's name _____
Last First Middle

Residence _____
Street City Postal Code

Mailing Address _____
Street City Postal Code

How long at this residence? _____Home #_____Work #_____ Cell #_____

Previous Address (if less than 3 years) _____

Email Address _____

Whom may may thank for referring you to our office? _____

MEDICAL HISTORY

Physician _____Date of last visit _____
Address _____Phone _____
Please circle Yes of No (If Yes, please fill in details)

Yes	No	Are you taking any medication? _____
Yes	No	Are you allergic to any medication? _____
Yes	No	Do you have a history of a major illness? _____
Yes	No	Have you had any operations? _____
Yes	No	Have you ever been involved in a serious accident? _____
Yes	No	Have you ever smoked or chewed tobacco? _____
Yes	No	Have you seen a physician in the last 12 months? Why? _____
		Female Patients Only:
Yes	No	Are you pregnant? _____
Yes	No	Has menstruation started? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

DENTAL HISTORY

General Dentist _____Date of last visit _____
What concerns you most about your teeth? _____

Yes	No	Are you presently in any dental pain? _____
Yes	No	Have you ever experienced any unfavorable reaction to dentistry? _____
Yes	No	Have your wisdom teeth been removed? _____
Yes	No	Have you ever lost or chipped any teeth? _____
Yes	No	Have there been any injuries to face, mouth or teeth? _____
Yes	No	Is any part of your mouth sensitive to temperature? Where? _____
Yes	No	Do your gums bleed when you brush? _____
Yes	No	Do you have any type of thumb or tongue habit? _____
Yes	No	Are you a mouth breather? _____
Yes	No	Have you ever seen an orthodontist? If yes, who and where? _____
Yes	No	Do your teeth or jaws ever feel uncomfortable when you wake in the morning? _____
Yes	No	Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you been told that you grind your teeth? _____
Yes No Do you have tension headaches? _____
Yes No Have you ever experience chronic ringing in your ears? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Stuart Matheson to perform a complete orthodontic evaluation.

Signature: _____Date: _____