

Patient's Medical/Dental History

Patient's Dentist: _____ Phone#: (____) _____ Last Visit: _____

What is patient's primary concern: _____

Patient's Physician: _____ Phone#: (____) _____ Last Visit: _____

Is patient presently being treated by a physician? Yes No Why?: _____

Has the patient's tonsils and adenoids been removed? Yes No

Has the patient ever had an unusual reaction to any drug? Yes No

Does patient have a speech problem, if so are they receiving therapy? Yes No

Has the patient any of the following?

- Heart Murmur
- Rheumatic Fever
- Mitral Valve Prolapse
- Pre Medication Required
- Anemia
- Bleeding Problems
- Gum Problems
- Tuberculosis
- Diabetes
- Epilepsy
- Convulsions/Seizures
- Immune Deficiency
- Smoke Cigarettes/Cigars
- Asthma
- Breathing Problems
- Frequent Colds
- Sinus Problems
- Cold Sores
- ADD/ADHD
- Ulcers
- Thyroid/Hormonal Imbalance
- Lip Biting
- Nail Biting
- Tongue Thrusting
- Presently Suck Thumb/Finger
- Arthritis
- Problems Opening/Closing
- Chewing Problems
- Jaw Popping
- Grinding/Clenching
- Concussion
- Injury to Teeth/Jaws
- Severe Headaches
- Facial Pain
- Any TMJ History
- Nervous Disorder
- Hearing Problem
- Latex Allergy
- Metal Allergy
- Seasonal Allergy
- Other Allergy: List: _____
- Major Surgery

Has Patient ever had orthodontic treatment or worn a retainer? Yes No

Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: _____

Names of Daily Medications? _____

Is there any other information about the patient's health we should know? _____

Whom may we thank for the referring you to our office?

Please circle all that apply:

My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List

Island Orthodontics Website Invisalign® Website Yellow Page Ad Newspaper Ad in: _____

My Friend/Relative Referred Me (list name(s)): _____

Other (please specify): _____

Signature: _____ Date: ___/___/___

Review by Doctor: _____ Date: ___/___/___