Paulus ORTHODONTICS

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About You

Name _____
Last First MI Mr Mrs Ms Dr
I prefer to be called _____ ☐ Male ☐ Female
Birth Date ___/___/___ Age _____
Home Address _____
_____
City State Zip
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Cell Phone # (___) _____
Home # (___) _____ Email _____
Work # (___) _____ Ext. _____
Occupation _____
Employer _____ How long? _____
Employer's Address _____
Where/when is the best time to reach you? _____
Other family members seen by us _____
Whom may we thank for referring you? _____
In the event of an emergency who should we contact?
_____ Phone: (___) _____

Spouse/Other Information

His/Her Name _____
Employer _____
Work # (___) _____ Ext. _____
Birth Date ___/___/___

Dental History

General Dentist _____
Date of Last Exam _____
What are the main goals that you would like orthodontics to accomplish? _____
_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No
Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No
Your current dental health is ☐ Good ☐ Fair ☐ Poor
Do you like your smile? ☐ Yes ☐ No
Do your gums ever bleed ☐ Yes ☐ No
Have you ever had an injury to your: mouth/teeth/chin ☐ Yes ☐ No
Do you have any missing or extra permanent teeth? ☐ Yes ☐ No
Do generally breath through your mouth? ☐ Yes ☐ No If yes: While awake? While asleep?
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Medical History

Your current medical condition is ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? _____
☐ No ☐ Yes; please explain _____
Physicians's Name _____
Are you taking any prescription/over-the-counter drugs?
☐ No ☐ Yes
Please list each one _____
_____

Have you ever had any of the following diseases, medical problems or medical procedures?

Y	N	Abnormal Bleeding
Y	N	Anemia/Radiation Treatment
Y	N	Artificial Bones/Joints/Valves
Y	N	Asthma
Y	N	Arthritis
Y	N	Blood Transfusion
Y	N	Cancer/Chemotherapy
Y	N	Congenital Heart Defects
Y	N	Diabetes
Y	N	Tuberculosis
Y	N	Difficulty Breathing
Y	N	Drug/Alcohol Abuse
Y	N	Emphysema
Y	N	Glaucoma
Y	N	Epilepsy/Seizures/Fainting
Y	N	Fever Blisters/Herpes
Y	N	Heart Murmur
Y	N	Heart Surgery/Pacemaker
Y	N	Hemophilia
Y	N	Hepatitis
Y	N	High/Low Blood Pressure
Y	N	HIV+/AIDS
Y	N	Hospitilization
Y	N	Kidney Problems
Y	N	Mitral Valve Prolapse
Y	N	Psychiatric Problems
Y	N	Rheumatic/Scarlet Fever
Y	N	Shingles
Y	N	Sinus Problems
Y	N	Severe/Frequent Headaches
Y	N	Heart Attack
Y	N	Ulcers/Colitis
Y	N	Venereal Disease

Are you pregnant? ☐ No ☐ Yes

Please list any serious medical condition(s) that you have ever had _____
_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Metals/Plastics	Y N	Other

Please list any other drugs/materials that you are allergic to:
_____
_____

I understand that the information that I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

_____
Reviewed Date