MEDICAL HISTORY

Patient's Physician: _____ City: _____ Last Visit Date: _____

Describe patient's general health: ☐ good ☐ fair ☐ poor

Is the patient under the care of a physician? ☐ yes ☐ no

If yes, please explain: _____

_____

Does the patient take medication before dental procedures? ☐ yes ☐ no

List any specific allergies or drug sensitivity: _____

_____

Patient's Height: _____ Father's Height: _____ Mother's Height: _____

Does the patient have a history of any of the following (check when yes)

☐ ADHD/ADD	☐ Epilepsy/Seizures	☐ Mental Health Disorders
☐ Allergies/Asthma	☐ Heart Condition	☐ Neurological Problems
☐ Anemia	☐ Heart Murmur	☐ Prolonged Bleeding
☐ Arthritis	☐ Hepatitis Type ____	☐ Rheumatic Fever
☐ Cancer	☐ HIV +/ AIDS	☐ Sleep Disorder
☐ Congenital Heart Defects	☐ Joint Replacement	☐ Surgery
☐ Diabetes	☐ Kidney/Liver Problems	☐ Thyroid Problems
☐ Emphysema/Tuberculosis	☐ Low/High Blood Pressure	☐ Ulcers

List any other medical problems we should know about: _____

_____

DENTAL HISTORY

Patient's Dentist: _____ City: _____ Last Visit Date: _____

Has the patient been evaluated or had orthodontic treatment before? ☐ yes ☐ no

Have there been any injuries to the face, mouth, teeth, chin? ☐ yes ☐ no

If yes, explain: _____

Have the adenoids or tonsils been removed? ☐ yes ☐ no

Does the patient have any missing or extra permanent teeth? ☐ yes ☐ no

Have any primary or permanent teeth ever been removed by a dentist? ☐ yes ☐ no

List any other dental problems we should know about: _____

_____

I understand that the information I have given is correct to the best of my knowledge, that will be held in the strictest confidence and it is my responsibility to inform this office of any medical or dental changes. I authorize release of any information to insurance carriers and to other health care providers. I authorize Fox Valley Orthodontics to perform any necessary dental services that are needed during diagnosis and treatment.

Signature of Patient: _____ Date: _____

Parent/Guardian of minor

Print Name: _____