Centre Orthodontics - Dr. Pnina Tepper-Adler

Medical and Dental history

To be signed by patient over 18 or parent/guardian

Name of Patient_____
Date _____

Are you healthy? _____ yes/no
Have you ever been hospitalized? When and why? _____ yes/no
_____
Are you taking any medication? _____ yes/no
Are you under any medical treatment _____ yes/no
Do you suffer or have you suffered from any of the following conditions:

- Rheumatic Fever _____ yes/no
- Hepatitis_____ yes/no
- Diabetes_____ yes/no
- Allergies, if yes to what?_____ yes/no
- Hypersensitivity to medication? Specify _____ yes/no
- Asthma or Hay fever_____ yes/no
- Heart disease, murmurs, congenital heart defects_____ yes/no
- Respiratory disorders _____ yes/no
- Hormonal disorders_____ yes/no
- Liver disorders_____ yes/no
- Bone disorders_____ yes/no
- Tuberculosis_____ yes/no
- Kidney disorders_____ yes/no
- Convulsions_____ yes/no
- Bleeding disorder_____ yes/no
- Neurological disorder _____ yes/no
- Other- specify_____ yes/no

Have you experienced any of the following:
Difficulty in breathing through your nose_____ yes/no
Injury to the face, jaws or teeth? If yes when and where?
_____ yes/no
Tooth clenching or grinding _____ yes/no
Recurrent head/neck/shoulder pain _____ yes/no
Pain in jaw joints? R/L _____ yes/no
Clicking or cracking in jaw joints? R/L _____ yes/no
Have you had any teeth extracted permanent or deciduas?_____ yes/no
Have you had any orthodontic treatment in the past_____ yes/no
Have you sucked a dummy or finger? _____ yes/no
Have you sucked a dummy or finger beyond age 4 ?_____ yes/no
Do you bite your nails?_____ yes/no

Name of parent/Guardian for patient under 18 years_____
Signature of patient over 18/parent/Guardian _____
Date_____

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Patient information sheet

Patient information:

Title: Mr / Mrs / Miss / Ms / Other (please circle) if other please specify_____
Given Name: _____
Surname: _____
Preferred Name: _____
Gender: Male / female (please circle)
Date of Birth: _____
Home Phone: _____ Work Phone: _____
Mobile Phone: _____
Address:_____
_____Post Code_____
Name of your General Dentist_____

Information on first party responsible for fees

Title: Mr & Mrs/Mr/Mrs/Miss/Ms/Other (please circle) if other specify_____
Responsible party Given Name: _____
Responsible party Surname: _____
Gender: Male / Female (please circle)
Home Phone: _____ Work Phone: _____
Mobile Phone: _____
Address:_____
_____Post Code_____
Email address: _____

Relationship to patient: Self/Father/Mother/Brother/Sister/Other_____(please circle)

Information on Second party responsible for fees

Title: Mr & Mrs/Mr/Mrs/Miss/Ms/Other (please circle) if other specify_____
Responsible party Given Name: _____
Responsible party Surname: _____
Gender: Male / female (please circle)
Home Phone: _____ Work Phone: _____
Mobile Phone: _____
Address:_____
_____Post Code_____
Email address: _____

Relationship to patient: Self/Father/Mother/Brother/Sister/Other_____(please circle)

Patient concerns:

What are your primary orthodontic concerns?

General appearance of front teeth _____ upper/lower
Straighten crowded teeth _____ upper/lower
Close spaces between the teeth_____ upper/lower
Move teeth back_____ upper/lower
Upper teeth protruding _____ upper/lower
Poor bite _____ yes/no
Inability to eat certain foods _____ yes/no