GOLDIE & DEESE ORTHODONTICS

7051 DR. PHILLIPS BLVD. SUITE 9 ORLANDO, FLORIDA 32819



Date ___

MEDICAL AND DENTAL INFORMATION ADULT GENERAL INFORMATION

Age in York or Date of Birth	Pat	ient's Name	Home Phone ()		
Address Autres, State					
City State Zp Occupation Social Security No. Employer Length of time employed with above employer: Yrs. Business Phone () Name of Spouse Scouplation Social Security No. Spouse's Cocupation Social Security No. Spouse's Cocupation Social Security No. Spouse's Employer If you are completing this form for another person, what is your relationship to that person? In case of emergency, notify Tulephone DENTAL INSURANCE INFORMATION Insured's Name Pol. # Insured's Name Pol. # Insured's Date of Birth MEDICAL HISTORY The patent's Medical and Dental History Information is very important. This information bears directly on the outcome of treatment and is also important in relepting to avoid complications. Thank you for training the Important. This information bears directly on the outcome of treatment and is also important in 1. Air you in good health? Yes No. A reyou now under the care of a physiciann? If so, what is the condition healty insured? A The name and address of my physician(s) is A reyou now under the care of a physiciann? His ow, what is the condition healty insuring? A The name and address of my physician(s) is A reyou had any serious liness, ceration, or been hospitalized in the past 5 years? His ow, what is the condition healty is the past 5 years? His ow, what has the illness or probleme? A Design the dark who or afficial heart valves, including non-prescription medicine? His ow, what has the illness or probleme? A Design the face, head or teeth? If yes, please give complete details including date(s) of occurance, nature of yes Not injury and who treated: A Design the face or afficial heart valves, including heart murrour or rhounatic heart disease, scaref fever, artificial joins? A Barry out had any serious liness, ceration, or been hospitalized in the past 5 years? His patient had any injuries to the face, head or teeth? If yes, please give complete details including date(s) of occurance, nature of yes Not injury and who treated: A Design the face or have you had any					
Cocupation Social Security No Employer		Number, Street			
Employer					
Length of time employed with above employer. Yrs. Business Phone () Name of Spouse Spouse's Age Business Phone () Spouse's Occupation			Social Security No		
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Spouse's Employer If you are completing this form for another person, what is your relationship to that person? If you are completing this form for another person, what is your relationship to that person? In case of emergency, notify Person responsible for this account Whom may we thank for referring you to our office DENTAL INSURANCE INFORMATION Insured's Name Pol. # Insured's Name Pol. # Insured's Date of Birth MEDICAL HISTORY The patient's Medical and Dental History Information is very important. This information bears directly on the outcome of treatment and is also important inhelping to avoid complications. Thank you for taking the time to answer these questions. 1. Are you in good health? Yes No. 3. Are you now under the care of a physician? 1f so, what is the condition being treated? 4. The name and address of my physician(s) is 5. Are you taking any medicine(s) including non-prescription medicine? 1f so, what medicine(s) are you taking? Yes No. 1f so, what medicine(s) are you taking? 1 See you take the presciple including non-prescription medicine? 1 See you take the presciple including non-prescription medicine? 1 See you have she tilness or problem? 2 Demaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? 2 Demaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? 2 Demaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? 2 Demaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? 2 Demaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? 3 Pes No. 4 Allergy 4 See No. 5 Allergy 5 Allergy 5 No. 6 Fainting spells or selatures, dizziness 7 Yes No. 6 Talling spells or selatures, dizzines	Ler	gth of time employed with above employer Yrs. Business Phone ()		
Spouse's Employer If you are completing this form for another person, what is your relationship to that person? Telephone Telephone	Nai	ne of Spouse's Age Busi	iness Phone ()		*************
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i. AIDS or HIV infection					
j. Thyroid problems Yes No					2.2
				Yes	No

m. Sto			1
	thritis or painful swollen joints	Yes	1
n. Kic	dney trouble	Yes	1
o. Tu	berculosis	Yes	1
p. Pe	rsistent cough	Yes	1
a Per	rsistent swollen glands in neck	Yes	1
r. Lo	w blood pressure	Yes	1
s Se	xually transmitted disease	Yes	1
t. Ep	illepsy or other neurological disease	Yes	1
u Are	e you pregnant?	Yes	1
v. Do	byou have any blood disorder such as anemia, hemophelia, leukemia, sickle cell disease?	Yes	1
	e you allergic or have you had a reaction to:		
a	Local anesthetics	Yes	1
h.	Penicillin or other antibiotics	Yes	1
	Other		
x. Ha	ave you had any problems associated with any previous dental treatment?	Yes	1
If s	so, explain		
y. Do	you have any disease, condition, or problem not listed above that you think I should know about?	Yes	١
If s	so, explain	relations in the second se	r negociani di seni
	DENTAL INFORMATION		
Wher	n was your last dental visit?		
		Voc	1
Have	you ever had teeth removed?	Yes Yes	
Have	your wisdom teeth been removed?	165	,
What	is your main reason for seeking orthodontic treatment?		
Have	you ever had orthodontic treatment (braces)?	Yes	1
If yes	when and by whom		
Have	you ever had an orthodontic examination, evaluation, conference or consultation?	Yes	
If yes	when and by whom		
Have	you ever had orthodontic records, such as x-rays, study models or photographs?	Yes	
If ves	when and by whom		
Do vo	ou feel your teeth can be straighter?	Yes	
Do vo	ou feel your occlusion (bite) needs to be improved?	Yes	
Have	your ever been told to see an orthodontist?	Yes	
If ves	s when and by whom		
Do y	ou feel your gingiva (gums) are healthy?	Yes	
Have	you ever been told that you have gum disease?	Yes	
If ves	s, when and by whom	***	
Have	you ever been advised to have periodontal (gum) treatment?	Yes	
Have	you ever had periodontal (gum) treatment?	Yes	
If ves	s, when and by whom		
Do y	ou feel your jaw joint is healthy	Yes	
If no,	please explain		
Does	s your jaw joint(s) click, crack, pop, grate or make any other sound(s)?	Yes	
If yes	s, please explain	\/- ·	
Do y	ou grind your teeth?	Yes	
Do y	ou clench your teeth?	Yes	
If voi	u are experiencing stress, do you grind your teeth?	Yes	
Has	your jaw ever "locked" open or closed?	Yes	
If ves	s, please explain	1/	
Have	g you ever been told you have a TMJ or "Jaw Joint" problem?	Yes	
If yes	s, when and by whom	17.	
. Have	g you ever been advised to have treatment for a TMJ or "Jaw Joint" problem?	Yes	
If ves	s, when and by whom	1/	
Have	you ever had treatment for a TMJ "Jaw Joint" problem?	Yes	
The	medical/dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any	/ change	(s).
	Date Signature		