GOLDIE & DEESE ORTHODONTICS
7051 DR. PHILLIPS BLVD.
SUITE 9
ORLANDO, FLORIDA 32819

American Association of Orthodontists

MEDICAL AND DENTAL INFORMATION

ADULT GENERAL INFORMATION

Date _____

Patient's Name _____ (Last / First / Middle) Home Phone (___) _____

Age in Years ____ Date of Birth ___/___/___ (mo. day yr.) Sex M F Height ____ Weight ____ Single ___ Married ___ Divorced ___ Separated ___

Address _____ (Number, Street) Business Phone (___) _____

City _____ State _____ Zip _____

Occupation _____ Social Security No. _____

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. _____

Spouse's Employer _____

If you are completing this form for another person, what is your relationship to that person? _____

In case of emergency, notify _____ Telephone _____

Referred by _____

Person responsible for this account _____

Whom may we thank for referring you to our office _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Pol. # _____

Insurance Co. _____ Group # _____

Insured's Employer _____ 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 in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Are you in good health?	Yes	No
2. My last physical examination was on _____		
3. Are you now under the care of a physician?	Yes	No
If 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?	Yes	No
If so, what medicine(s) are you taking? _____		
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?	Yes	No
If so, what was the illness or problem? _____		
7. Has patient had any injuries to the face, head or teeth? If yes, please give complete details including date(s) of occurance, nature of injury and who treated: _____	Yes	No
_____		
_____		
8. Do you have or have you had any of the following diseases or problems?		
a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints?	Yes	No
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriorsclerosis, stroke)	Yes	No
c. Allergy	Yes	No
d. Sinus trouble	Yes	No
e. Asthma or hay fever	Yes	No
f. Fainting spells or seizures, dizziness	Yes	No
g. Diabetes	Yes	No
h. Hepatitis, jaundice or liver disease	Yes	No
i. AIDS or HIV infection	Yes	No
j. Thyroid problems	Yes	No
k. Respiratory problems, emphysema, bronchitis, etc.	Yes	No

l. Arthritis or painful swollen joints ..... Yes No
m. Stomach ulcer or hyperacidity ..... Yes No
n. Kidney trouble ..... Yes No
o. Tuberculosis ..... Yes No
p. Persistent cough ..... Yes No
q. Persistent swollen glands in neck ..... Yes No
r. Low blood pressure ..... Yes No
s. Sexually transmitted disease ..... Yes No
t. Epilepsy or other neurological disease ..... Yes No
u. Are you pregnant? ..... Yes No
v. Do you have any blood disorder such as anemia, hemophelia, leukemia, sickle cell disease? ..... Yes No
w. Are you allergic or have you had a reaction to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Other _____
x. Have you had any problems associated with any previous dental treatment? ..... Yes No
   If so, explain _____
   _____
y. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
   If so, explain _____

DENTAL INFORMATION

1. When was your last dental visit? _____
2. The name and address of my dentist is: _____
   _____
3. Have you ever had teeth removed? ..... Yes No
4. Have your wisdom teeth been removed? ..... Yes No
5. What is your main reason for seeking orthodontic treatment? _____
   _____
6. Have you ever had orthodontic treatment (braces)? ..... Yes No
   If yes, when and by whom _____
7. Have you ever had an orthodontic examination, evaluation, conference or consultation? ..... Yes No
   If yes, when and by whom _____
8. Have you ever had orthodontic records, such as x-rays, study models or photographs? ..... Yes No
   If yes, when and by whom _____
9. Do you feel your teeth can be straighter? ..... Yes No
10. Do you feel your occlusion (bite) needs to be improved? ..... Yes No
11. Have your ever been told to see an orthodontist? ..... Yes No
    If yes, when and by whom _____
12. Do you feel your gingiva (gums) are healthy? ..... Yes No
13. Have you ever been told that you have gum disease? ..... Yes No
    If yes, when and by whom _____
14. Have you ever been advised to have periodontal (gum) treatment? ..... Yes No
15. Have you ever had periodontal (gum) treatment? ..... Yes No
    If yes, when and by whom _____
16. Do you feel your jaw joint is healthy ..... Yes No
    If no, please explain _____
17. Does your jaw joint(s) click, crack, pop, grate or make any other sound(s)? ..... Yes No
    If yes, please explain _____
18. Do you grind your teeth? ..... Yes No
19. Do you clench your teeth? ..... Yes No
20. If you are experiencing stress, do you grind your teeth? ..... Yes No
21. Has your jaw ever "locked" open or closed? ..... Yes No
    If yes, please explain _____
22. Have you ever been told you have a TMJ or "Jaw Joint" problem? ..... Yes No
    If yes, when and by whom _____
23. Have you ever been advised to have treatment for a TMJ or "Jaw Joint" problem? ..... Yes No
    If yes, when and by whom _____
24. Have you ever had treatment for a TMJ "Jaw Joint" problem? ..... Yes No

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

_____ (Date)

_____ Examining Dentist