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

American Association of Orthodontists

MEDICAL AND DENTAL INFORMATION

PRELIMINARY INFORMATION

Today's Date _____

Patient's Name _____ (Last / First / Middle) Nickname _____ Sex _____

Date of Birth ____/____/____ (mo. / day / yr.) Age in Years _____ School _____ Grade _____

Home Address _____ (Street No. / Street Name) Phone _____

City _____ State _____ Zip _____

Father's Name _____ (Last / First / Middle) Social Sec. No. _____

Father's Occupation _____ Business Phone No. _____

Father's Employer _____

Mother's Name _____ (Last / First / Middle) Social Sec. No. _____

Mother's Occupation _____ Business Phone No. _____

Mother's Employer _____

Person Responsible for 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. Is patient in good health?	Yes	No
2. Patient's last physical examination was on _____		
3. Is patient now under the care of a physician?	Yes	No
If so, what is the condition being treated? _____		
4. The name and address of patient's physician(s) is _____		
5. Is patient taking any medicine(s) including non-prescription medicine?	Yes	No
If so, what medicine(s) are being taken? _____		
6. Has patient had any serious illness, operation, or been hospitalized in the past 5 years?	Yes	No
If so, what was the illness or problem? _____		
7. Have Tonsils and Adenoids been removed? If yes, when? _____	Yes	No
8. 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
9. Does patient have or has patient 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

10. Does patient have any blood disorder such as anemia, hemophelia, leukemia, sickle cell disease? ..... Yes No
11. Is patient allergic or has patient had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    Other _____
12. Has patient had any problems associated with any previous dental treatment? ..... Yes No
    If so, explain _____
13. Does patient have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____
14. Onset of Puberty: (Boys - Voice changed; Girls - Started Menstruation) ..... Yes No

DENTAL INFORMATION

1. When was patient's last dental visit? _____
2. The name and address of patient's dentist is: _____
3. I would describe patient's temperament as: _____
4. Patient's hobbies or sports interests are: _____
5. Is patient a mouth breather? ..... Yes No
6. Has patient ever had a finger or thumb habit? ..... Yes No
7. Are patient's teeth sensitive to cold, hot or foods? ..... Yes No
8. Would patient mind wearing braces? ..... Yes No
    If yes, please explain _____
9. What is patient's main reason for seeking orthodontic treatment? _____
10. Has patient ever had orthodontic treatment (braces)? ..... Yes No
    If yes, when and by whom _____
11. Has patient ever had an orthodontic examination, evaluation, conference or consultation? ..... Yes No
    If yes, when and by whom _____
12. Has patient ever been told to see an orthodontist? ..... Yes No
    If yes, when and by whom _____
13. Do you feel patient's gingiva (gums) are healthy? ..... Yes No
    If no, please explain _____
14. Do patient's gums bleed when brushing? ..... Yes No
15. Will patient follow instructions regarding good oral hygiene? ..... Yes No
16. Do you feel patient's jaw joint is healthy? ..... Yes No
    If no, please explain _____
17. Does patient's jaw joint(s) click, crack, pop, grate or make any other sound(s)? ..... Yes No
18. Does patient grind teeth? ..... Yes No
19. Does patient clench teeth? ..... Yes No
20. Has patient's jaw ever "locked" open or closed? ..... Yes No
    If yes, please explain _____
21. Has patient ever been told that patient has a TMJ or "Jaw joint" problem? ..... Yes No
    If yes, when and by whom _____
22. Has patient ever been told that they have jaw arthritis? ..... Yes No
    If yes, when and by whom _____

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