CREED
ORTHODONTICS

CONFIDENTIAL

Medical/Dental History Form

PATIENT

Date_____

Last Name_____ First Name_____ Middle Initial_____

Title: Mr. Mrs. Ms. Miss. Dr. Other_____ I prefer to be called_____

Birth date_____ Sex: Male Female Social Security # _____ - _____- _____

Marital Status: Single Married Separated Divorced Widowed

Home Address_____ City_____ State_____ Zip Code_____

Cell Phone(_____)_____ Home Phone (_____)_____ Work Phone (_____)_____

E-mail Address_____

Occupation_____ Employer_____

FOR PATIENTS UNDER THE AGE OF 18

Name of Legal Guardian(s)_____Relationship_____

Mother's Last Name_____ First Name_____ Title: Mr. Mrs. Ms. Miss. Dr.

Home Address *(if different)*_____ City_____ State_____ Zip Code_____

Cell Phone(_____)_____ Work Phone (_____)_____ E-mail Address_____

Fathers's Last Name_____ First Name_____ Title: Mr. Mrs. Ms. Miss. Dr.

Home Address *(if different)*_____ City_____ State_____ Zip Code_____

Cell Phone (_____)_____ Work Phone (_____)_____ E-mail Address_____

PREFERRED METHOD OF CONTACT

May we contact you and/or leave information regarding your treatment and/or appointment reminders:

On your cell phone voicemail? **yes no** On your work voicemail system? **yes no**

On your answering machine? **yes no** Through your e-mail? **yes no**

Consent to electronic communication: Electronic communication such as email is not secure and there is a risk that the information in the email can be accessed by a third party while in transit. I understand and consent to electronic communication.

Patient/Legal Guardian Signature _____

IN CASE OF EMERGENCY

Spouse or Closest Relatives Name(s)_____

Title: Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to Patient_____

Home Address_____ City_____ State_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Home Address *(if different)*_____ City_____ State_____ Zip Code_____

Home Phone (_____)_____ Cell Phone (_____)_____

E-mail Address_____

Social Security #_____-_____-_____Employer:_____

DENTAL INSURANCE

Primary Policy Holder's Full Name _____ Birthdate _____

Social Security # _____-_____-_____ Relationship to Patient _____

Address and Phone *(if different)*_____

Employer_____ Address _____

Insurance company _____ Group # _____ID #_____

Does this policy have orthodontic benefits? Yes No Don't know

Secondary Policy Holder's Full Name _____ Birthdate _____

Social Security # _____-_____-_____ Relationship to Patient _____

Address and Phone *(if different)*_____

Employer_____ Address _____

Insurance company _____ Group # _____ID #_____

Does this policy have orthodontic benefits? Yes No Don't know

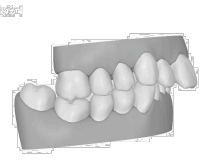
DENTIST

Patient's Dentist _____ Address_____ City_____ State _____

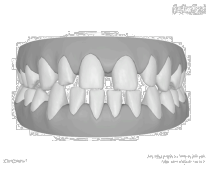
Last seen _____ Reason _____Next appointment _____

GENERAL INFORMATION

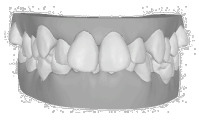
What concerns you about your teeth?



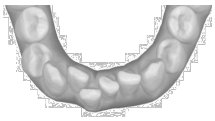
Over Jet (Buck Teeth)



Spacing



Overbite



Crowding

Other _____

Who suggested that you might need orthodontic treatment?_____

Have you had any previous orthodontic treatment? Please describe._____

Whom may we thank for referring you to our office?_____

Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. ***For the following questions mark yes, no, or don't know/understand (dk/u).***

MEDICAL HISTORY

Now or in the past, have you had:

yes no dk/u	Birth defects or hereditary problems?
yes no dk/u	Bone fractures, or major injuries?
yes no dk/u	Any injuries to face, head, neck?
yes no dk/u	Arthritis or joint problems?
yes no dk/u	Endocrine or thyroid problems?
yes no dk/u	Diabetes or low sugar?
yes no dk/u	Kidney problems?
yes no dk/u	Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u	Stomach ulcer, hyperacidity, acid reflux?
yes no dk/u	Immune system problems?
yes no dk/u	History of osteoporosis?
yes no dk/u	Gonorrhea, syphilis, herpes, sexually transmitted diseases?
yes no dk/u	AIDS or HIV positive?
yes no dk/u	Hepatitis, jaundice or other liver problem?
yes no dk/u	Tuberculosis?
yes no dk/u	Seizures, fainting spells, neurologic problem?
yes no dk/u	Mental health disturbance or depression?
yes no dk/u	Vision, hearing, or speech problems?
yes no dk/u	History of eating disorder (anorexia, bulimia)?
yes no dk/u	High or low blood pressure?
yes no dk/u	Excessive bleeding or bruising, anemia?
yes no dk/u	Chest pain, shortness of breath, tire easily, swollen ankles?
yes no dk/u	Heart defects, heart murmur, rheumatic heart disease?
yes no dk/u	Angina, arteriosclerosis, stroke or heart attack?
yes no dk/u	Skin disorder (other than common acne)?
yes no dk/u	Frequent headaches or migraines?
yes no dk/u	Asthma, sinus problems, hayfever?
yes no dk/u	Tonsil or adenoid condition?
yes no dk/u	Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following:

yes no dk/u	Local anesthetics (novocaine, lidocaine, xylocaine)
yes no dk/u	Latex (gloves, balloons)
yes no dk/u	Aspirin
yes no dk/u	Ibuprofen (Motrin, Advil)
yes no dk/u	Penicillin
yes no dk/u	Other antibiotics
yes no dk/u	Metals (jewelry, clothing snaps)
yes no dk/u	Acrylics

DENTAL HISTORY

Now or in the past, have you had:

yes no dk/u	Permanent or extra (supernumerary) teeth removed?
yes no dk/u	Supernumerary (extra) or congenitally missing teeth?
yes no dk/u	Chipped or injured primary or permanent teeth?
yes no dk/u	Any sensitive or sore teeth?
yes no dk/u	Bleeding gums, bad taste or mouth odor?
yes no dk/u	Jaw fractures, cysts, infections?
yes no dk/u	Any teeth treated with root canals or pulpotomies?
yes no dk/u	"Gum boils," frequent canker sores or cold sores?
yes no dk/u	History of speech problems or speech therapy?
yes no dk/u	Difficulty breathing through nose?
yes no dk/u	Food impaction between the teeth?
yes no dk/u	Mouth breathing habit or snoring at night?
yes no dk/u	Frequent oral habits (sucking finger, chewing pen, etc.)?
yes no dk/u	Teeth causing irritation to lip, cheek or gums?
yes no dk/u	Tooth grinding or clenching?
yes no dk/ u	Clicking, locking in jaw joints?
yes no dk/u	Soreness in jaw muscles or face muscles?
yes no dk/u	Have you ever been treated for "TMJ" or "TMD" problems?
yes no dk/u	Any broken or missing fillings?
yes no dk/ u	Have you ever been diagnosed with gum disease (periodontal disease)?
yes no dk/u	Have you ever had an orthodontic consultation or treatment before now?

FAMILY MEDICAL HISTORY

Have your parents/siblings ever had any of the following health problems?

yes no dk/u	Bleeding Disorder?
yes no dk/ u	Diabetes?
yes no dk/u	Arthritis?
yes no dk/u	Severe Allergies?

Please explain: _____

_____

_____

_____

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe._____

Do you or have you ever had a substance abuse problem?_____

Do you chew or smoke tobacco?_____

How often do you brush?_____

How often do you floss?_____

Women: Are you pregnant or trying to become pregnant? Yes No

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date_____