Warrington Orthodontics
Ceceilia M. Markham, DMD – Bryan Foley, DMD

Welcome to our office. Please complete this medical/dental questionnaire. It will help us best meet your orthodontic needs. The answers to the following questions are for office records only and will be considered confidential

Today's date:_____

PATIENT INFORMATION:

Last Name_____ First_____ Middle_____

Date of Birth_____ Age in Years:_____ Months:_____

Sex: M or F Is Patient Adopted? _____

Cell Phone No. _____E-mail _____

Street Address_____

City_____ State_____ Zip Code_____

School _____ Grade_____

Name and ages of other children in family _____

Other family members treated by our office _____

How were you referred to our office? _____

Is patient or guardian military/veteran, first responder, teacher, or medical professional? Yes or No

ADULT PATIENTS ONLY:

Employed by _____ SS # _____

Business Phone No. _____ Bus. Address _____

Business E-mail _____

Spouse's Name _____

Employed by_____ Work Phone No._____

Address _____

EMERGENCY CONTACT:

In case we cannot reach patient and or parent:

Person to Contact_____ Phone No._____

IF PARENTS/GUARDIANS ARE FINANCIALLY RESPONSIBLE PLEASE COMPLETE:

Father or Guardian:

Last Name_____ First_____ Middle_____

Home Phone No. _____Email _____

Street Address_____

City_____ State_____ Zip Code_____

Employed by _____

Business Phone No. _____

Mother or Guardian:

Last Name_____ First_____ Middle_____

Home Phone No._____Email_____

Street Address_____

City_____ State_____ Zip Code_____

Employer _____

Business Phone No. _____

Parents are: ____Married ____Widowed ____ Separated ____ Single ____ Divorced

INSURANCE:

Do you have insurance that provides for orthodontic care? _____ Name of the insurance co: _____

Name of insured: _____ Birthday of insured: _____/_____/_____

Social Security or ID number of insured: _____

Dental History

A thorough and complete history is vital to a proper orthodontic evaluation.

Name and location of Patient's Dentist_____

Date of most recent dental examination _____

How often does patient brush? _____ Floss _____?

What is patient's (or parent's) primary concern? Why are you here? _____
_____

Yes No DK For the following questions check Yes, No, or Don't Know

___ ___ ___ Does patient have difficulty brushing his/her teeth conscientiously?
___ ___ ___ Supernumerary (extra) or congenitally missing teeth?
___ ___ ___ Permanent or "extra" teeth removed?
___ ___ ___ Chipped or otherwise injured primary (baby) or permanent teeth?
___ ___ ___ Does the patient have any jaw, joint, or facial pain?
___ ___ ___ Periodontal "Gum problems" or treated for periodontal problems?
___ ___ ___ Thumb, finger or lip sucking habit? Until age _____?
___ ___ ___ Nail biting, lip biting, tongue thrusting or grinding habits? Which? _____
___ ___ ___ History of speech problems?
___ ___ ___ Mouth breathing habit, snoring, difficulty in breathing?
___ ___ ___ Any relative with similar tooth or jaw relationships/problems?
___ ___ ___ Has patient ever had a prior orthodontic examination or treatment?
___ ___ ___ Would patient object to wearing orthodontic appliances (braces) should they be indicated?
___ ___ ___ Have the teeth or either jaw been injured? How old was the patient? _____
What was the cause of the accident? _____
Which teeth and/or jaw was involved? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

Medical History

Name and location of Physician _____

Yes No DK – Yes, No or Don't Know

___ ___ ___ Birth defects or hereditary problems?
___ ___ ___ Rheumatoid or arthritic conditions?
___ ___ ___ Endocrine or thyroid problems?
___ ___ ___ Kidney problems?
___ ___ ___ Cancer or been treated for a tumor?
___ ___ ___ Stomach ulcer or hyperacidity?
___ ___ ___ Polio, mono, tuberculosis, pneumonia?
___ ___ ___ Problems of the immune system?
___ ___ ___ AIDS or HIV positive?
___ ___ ___ Sexually Transmitted Diseases?
___ ___ ___ Hepatitis, jaundice or liver problem?
___ ___ ___ Fainting spells, seizures, epilepsy or neurological problems?
___ ___ ___ Mental health or behavioral problem?
___ ___ ___ Vision, hearing, tasting or speech difficulties?
___ ___ ___ Loss of weight recently, poor appetite?
___ ___ ___ Excessive bleeding, black and blue tendency, anemia or bleeding disorders?
___ ___ ___ High or low blood pressure?
___ ___ ___ Tires easily?
___ ___ ___ Chest pain, shortness of breath or swelling ankles?

Yes No DK

___ ___ ___ Diabetes?
___ ___ ___ Cardiovascular problem (heart trouble), heart murmur, heart attack, angina, coronary insufficiency, stroke, inborn heart defects or rheumatic heart? If yes please list: _____
_____
___ ___ ___ Do you have a poor or altered diet?
___ ___ ___ Frequent headaches, colds or sore throats?
___ ___ ___ Eye, ear, nose or throat condition?
___ ___ ___ Hayfever, asthma, sinus trouble, hives?
___ ___ ___ Tonsil or adenoid conditions?
___ ___ ___ Allergies or drug reactions?
___ ___ ___ Known Drug Allergies. Please list:
_____
_____
___ ___ ___ Are you taking medication, nutrient supplements or non-prescription medicine? Please name them
_____
___ ___ ___ Is patient a smoker?
___ ___ ___ Does the patient currently have or ever had a substance abuse problem?

Yes No DK

___ ___ ___ Operations or Hospitalized? For _____
_____

___ ___ ___ Being treated by another health care professional? For _____

___ ___ ___ Other physical problems or symptoms? List: _____
_____

___ ___ ___ Onset of puberty *(only need to answer for age 21 and under)*
Females - onset of menstruation (approx. date) _____?
Males - onset of voice change (approx. date) _____?

___ ___ ___ Does patient have difficulty following directions?
___ ___ ___ Does patients have learning disabilities or need extra help with instructions?
___ ___ ___ Is patient sensitive, self-conscious?

Date of latest physical exam?_____ Weight_____ Height_____

I have read and understand the above questions.
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. If there are any changes later to this history records or medical/dental status I will inform this practice.

_____ _____
Signature of patient or guardian **Date**

Medical History Update or Changes:
Please date and initial:
_____
_____

MEDICAL ALERT SUMMARY

OFFICE USE ONLY