PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
Are you currently under medical treatment?...	___	___
Please explain:_____		
Are you taking any medications(s)?	___	___
If yes, please list and explain_____	___	___
_____		
Have you taken, or are you taking any bisphosphonates. If yes, for what condition?	___	___
_____		
Are you or could you be pregnant?.....	___	___

ALLERGIES

Are you allergic to or have you had any reactions to:	Yes	No
Penicillin/Amoxicillin.....	___	___
Other Antibiotics	___	___
If yes, please list_____		
Metals.....	___	___
Latex Products	___	___
Other	___	___
If yes,please explain_____		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
High Blood Pressure.....	___	___	Tuberculosis.....	___	___
Rheumatic Fever.....	___	___	Thyroid Problems.....	___	___
Heart Murmur.....	___	___	Kidney Diseases.....	___	___
Mitral Valve Prolapse.....	___	___	Respiratory Problems.....	___	___
Heart Conditions.....	___	___	Diabetes.....	___	___
Epilepsy/Convulsions.....	___	___	Asthma	___	___
Fainting/Seizures.....	___	___	X-ray/Radiation (Cancer) Therapy.....	___	___
Hay Fever/Allergies.....	___	___	AIDS or HIV Infection	___	___
ADHD.....	___	___	Hepatitis/Jaundice	___	___
Any developmental /genetic issues that would effect how we communicate with your child?	___	___	Other	___	___

If yes, explain: _____

PATIENT DENTAL HISTORY

Dentist: _____ _____

Name Address Phone Date of Last Appointment

Do you authorize release of information about orthodontic treatment to the patient's dentist Yes ___ No___

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?.....	___	___	Do you have frequent headaches?	___	___
Are your teeth sensitive to:			Do you clench or grind your teeth?	___	___
hot or cold food/liquids?	___	___	Do you bite your lips or cheeks?	___	___
sweet or sour foods/liquids?.....	___	___	Have you had any blows to your teeth? ...	___	___
Do you feel pain in any of your teeth?	___	___	Have you ever had any difficult extractions in the past?	___	___
Do you have any or frequently get sores in or around your mouth?	___	___	Have you ever had any prolonged bleeding following extractions?	___	___
Have you had any head, neck or jaw injuries?.....	___	___	Have you had prior orthodontic:		
Have you ever experienced any of the following problems in your jaw?	___	___	-Treatment?	___	___
-Clicking?	___	___	-Consultation?	___	___
-Pain?	___	___	Do you have, or have you had thumb/finger habit?	___	___
-Difficulty in opening or closing?	___	___			
-Difficulty in chewing?	___	___			

PLEASE EXPLAIN THE NATURE OF THE ORTHODONTIC PROBLEM IN YOUR OWN TERMS:

_____

AUTHORIZATION AND RELEASE

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Simi to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child for orthodontic care to the patient's general dentist, third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Simi, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ ___/___/___

Signature of patient or parent if patient is a minor Date

Doctor's Comments:

_____

Date Reviewed:_____ Date Reviewed:_____ Date Reviewed:_____ Rvsd:10/10