BLAIS ORTHODONTICS

ADULT ORTHODONTIC FORM

Date_____

Patient's name

_____

Last First Middle

Address

_____

Street City Zip

Home phone_____ Work phone

_____

Cell/other phone_____ Email address

_____

Patient's Dentist_____

Physician_____ Birthdate_____

Employed By_____ Occupation_____

Spouse's Name_____

Names and ages of children in family_____

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

MEDICAL HISTORY

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient in good health? _____

Yes No Does the patient have any history of major illness? _____

Yes No Is the patient taking any medication? _____

Yes No Is the patient allergic to any medication? _____

Yes No Has the patient had any operations? _____

Yes No Have you ever smoked or chewed tobacco? _____

Yes No Ever been involved in a serious accident? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Yes No Have tonsils and adenoids been removed? If so, what age? _____

Yes No Are all of the members of your family currently in good health? _____

Yes No Does anyone in your family have an elevated temperature? _____

Female Patients only:

Yes No Are you pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

BLAIS ORTHODONTICS

DENTAL HISTORY

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have your wisdom teeth been removed? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have “tension” headaches?_____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No Are you aware that some appointments will be during work hours? _____

Signature: _____