MESSINGHAM ORTHODONTICS

MEDICAL HISTORY Patient Name:_____

Physician_____ Date of Last Visit _____

Address_____ Phone _____

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

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident?_____

Circle any of the medical conditions below that you have had or currently have.

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? _____

_____

DENTAL HISTORY

Dentist_____ Date of last visit_____

Referred to our office by?_____

What concerns you most about your teeth? _____

Have you ever seen an orthodontist? If yes, who and when? _____

List other members in your family that have received orthodontic treatment? _____

_____

Yes No Are you presently in any dental pain? _____

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

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 or pressure? _____

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 Are you aware of your jaw clicking or popping?_____

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

Yes No Do you clinch or 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 school/work hours? _____

Please list some hobbies or interests _____

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started?_____

Emergency Information

Name of nearest relative not living with you?_____

Complete address_____

Street City Zip

Phone_____ Other: _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize **Dr. Jason A. Messingham, DDS, MS** to perform a complete orthodontic evaluation.

I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____Date: _____