GLANDER | ROCHFORD
ORTHODONTICS

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Patient's Family Information, Medical, & Dental History (Adult)

(please complete in ink)

Today's Date _____

Name _____ Nickname _____ Age____ Sex ____ Date of Birth _____
First Last M.I.

Address _____ Tel. # (____) _____
Street City Zip

Employed by _____ Occupation _____ Position _____

Employer Address _____ Work Tel. # (____) _____
Street City Zip

Best telephone number to call for appointments (During Business Hours) _____

Best Cell Phone # _____ Best E-mail Address _____

Social Security Number of Patient (for accounting purposes only) _____

Marital Status: Single Married Separated Divorced Widowed Remarried Other

Husband/Wife Name _____ Date of Birth _____
First Last M.I.

Social Security Number _____ (for insurance purposes only)

Employed by _____ Occupation _____ Position _____

Employer Address _____ Work Tel. # (____) _____
Street City Zip

Cell. # (____) _____

Patient's Family Dentist _____
Name Address Tel. #

Patient's Family Physician _____
Name Address Tel. #

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

Do you have Orthodontic Insurance? ____Yes ____No Name of Insurance Company _____
(This may be different from Dental Insurance)

Do you have Medical Insurance? ____Yes ____No Name of Insurance Company _____

If responsible party is other than the patient, please give information: ___ Not Applicable

Name _____ S.S. # _____ Relationship to patient _____
(for Insurance purposes only)

Address _____ Tel. # (____) _____
Street City Zip

Does Responsible Party have Orthodontic Insurance? _____Yes _____No Name of Insurance Company _____
(This may be different from Dental Insurance)

Does Responsible Party have Medical Insurance? _____Yes _____No Name of Insurance Company _____

MEDICAL HISTORY

Have you had or do you have any of the following?

	Yes	No		Yes	No
Rheumatic Fever			Persistent Headaches		
Heart Murmur			Neck Pains		
High Blood Pressure			Nerve or Brain Disease		
Heart Attack/Stroke			Migraine or Headaches		
Blood Vessel Disease			Epilepsy		
Blood Disorder			Mental Health Problems		
AIDS/HIV Infection			Bone Disorders		
Hepatitis (Any type)			Arthritis (Any type)		
Diabetes			Sleep Apnea		
Ulcers			Ear Disorder		
Herpes (Any type)			Sinus Infection		
Psoriasis			Swollen Glands		
Cancer			Allergies		

Comments _____

Please list any other significant information about your medical history: _____

_____

_____

Yes No

Are you under a physician's care at present? If yes, reason _____

Are you presently, or have you ever been, under the care of a psychiatrist or psychologist?

If yes, describe _____

Are you currently taking any medication? If yes, describe _____

Are you allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, list _____

Have you ever had any general anesthesia? When? _____

Do you take vitamins? If yes, what type? _____

Do you take calcium? _____

FEMALE PATIENTS

Yes No

Have you had or has anyone in your family had osteoporosis?

Is there a possibility that you could be pregnant?

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DENTAL HISTORY

Yes No

Do any teeth hurt? If yes, upper right upper left lower right lower left

Have any wisdom teeth been removed? How many? _____

Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe _____

Have you ever had any previous orthodontic treatment (braces)? If yes, when _____

If yes, doctor's name and address _____

TMD HISTORY

Do you experience: Headaches Ear pain Face Pain Other _____

How long have you had the symptoms?

Is the pain: Constant Aching Burning Stabbing Other _____

Worse in the morning? Worse in the afternoon?

Do you experience: Pain in your ears Problems with hearing Dizziness Ringing or buzzing in ears

Describe your problem in your own words _____

Yes No

Have there been any injuries to your mouth or teeth? If yes, describe _____

Have you ever had any injury to the head or neck area? If yes, describe _____

Have you ever fallen and bumped your chin, or received any trauma to your jaws? If yes, describe _____

Have you ever had any surgery in the head and neck area? If yes, describe _____

Do you clench or grind your teeth? If yes, while sleeping under stress Other _____

Are your teeth sore or sensitive?

Do your jaw muscles ever feel tired? If yes, when _____

Do you feel as though you are under a lot of stress?

Do you ever notice soreness, tightness or pain in the muscles around the jaws or face? If yes, describe _____

Does it hurt to chew or open wide? If yes, where does it hurt? _____

Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
Clicking:				
Grating:				

Did these joint sounds begin gradually or suddenly? gradually suddenly

Was there some specific event that started the joint sound or pain? If yes, describe _____

Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____

Have your jaws ever "locked" closed? If yes, describe _____

Yes No

Have your jaws ever "locked" wide open? If yes, describe _____

Do you have pain in your jaw joints? If yes, right left Since when? _____

Did your pain start gradually or suddenly? gradually suddenly

During what activity? _____ Describe nature of pain _____

What increases the pain? _____ What decreases the pain? _____

Do you have any of the following habits?

Yes	No		Yes	No	
		Finger/Thumb Sucking			Caffeinated Beverages (coffee, soda, tea)
		Lip Biting			Do you exercise regularly?
		Nail Biting			
		Gum Chewing			
		Ice Chewing			
		Smoke or Smokeless Tobacco User			

Please describe why you sought this consultation _____

Yes No

Have you ever been treated for this problem before? If yes, please describe the diagnosis and treatment _____

_____

Has any other member of the family had orthodontic treatment?

Has any other member of the family been a patient in this office?

Name(s) _____

We recognize that patients sometimes have specific concerns that may not be addressed by the questions in this Clinical History Form. Please feel free to include any other information regarding your clinical history, or any other concerns that you may have, in the space below. If necessary, please add another sheet of paper.

_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

(Signature of Patient) Date

Doctor's Notes _____

_____

_____

_____

_____

_____

_____ _____

(Doctor's Signature) Date

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