Dental History Information

Name of your General Dentist _____

Date of your last dental cleaning and check up _____

Have you ever experienced jaw/joint pain? _____ *Do your gums bleed?* _____

Have you ever had any type of injury to your mouth, teeth or chin before? _____

If so please explain _____

Do you breathe through your mouth? _____ *Do you have any missing/extra permanent teeth?* _____

Orthodontic History

***Are you currently in orthodontic treatment?* _____ *** Doctors Name:* _____

***Have you had any orthodontic treatment within the last 6 months?* _____

Medical Information

Name of your Medical Doctor _____

Are you in good physical health? _____ *If no please explain* _____

Are you taking prescription/over the counter medications? _____ *Medications*_____

***** Women Only:***

Are you taking Birth Control Pills? _____ *Are you pregnant or nursing?* _____

Medical Health History

Abnormal bleeding ____ *Blood Transfusion* _____ *Anemia* ____ *Heart Murmur* ___ *Stroke* _____

Cancer ____ *Chemotherapy* ____ *Radiation Treatment* _____ *High/Low Blood Pressure* ____

Asthma/Difficulty breathing _____ *Emphysema* _____ *Artificial Bones/joints/valves* _____

Diabetes _____ *Tuberculosis* _____ *Hemophilia* ____ *Hepatitis* ____ *Aids/HIV+* _____

Epilepsy _____ *Seizures* _____ *Fainting* ____ *Frequent Headaches* _____ *Glaucoma* _____

Kidney Problems ___ *Ulcers* ____ *Colitis* ____ *Alcohol Abuse* ___ *Drug Abuse* ____

Fever Blisters ____ *Herpes* ___ *Shingles* _____ *Venereal Disease* ____ *Psychiatric Treatment* ____

Any known Allergies to Medications

Dental Anesthetics ____ *Aspirin* ____ *Codeine* ___ *Erythromycin* ____ *Penicillin* ____ *Tetracycline* _____

Any Metal ____ *Any Plastics* ___ *Latex* _____ *Nickel* _____ *Other Allergies* _____

I understand that the information is correct to my knowledge and I am aware it is my responsibility to notify the office of Thresher Orthodontics of any changes.

Signature of Responsibility Party _____ ***Date*** _____