BayTree ORTHODONTICS

It is very important that we have a thorough medical and dental background before we begin treatment. Please complete the following to the best of your ability.

Patient Medical History

Today's Date: ______________________________ Date of last Medical Exam:___________________________
Month / Day / Year   Month / Day / Year

Are you currently under the care of a physician? Yes No
If Yes, why? ____

Have you ever been hospitalized for a surgery or serious illness? Yes No
If Yes, for what? ____
And when? ____

Are you currently taking any medications? Yes No
If Yes, which ones? ____

Do you have any allergies (other than seasonal)? Yes No
If Yes, what are you allergic to? ____
What type of reaction do you have? ____

Do you use tobacco? Yes No
Alcohol? Yes No
Is there a chance you may be pregnant? Yes No

Have you ever been diagnosed with or experienced any of the following? (check all that apply)

Asthma	Heart Disease	Cancer
Diabetes (Type I or II)	Heart Attack	HIV/AIDS
Fainting	Chest Pains	Hepatitis
Seizures	Angina	Tuberculosis
Frequent Tiredness	Heart Murmur	Kidney Disease
Epilepsy/Convulsions	Respiratory Problems	Liver Disease
Autism	Emphysema	Hepatitis/Jaundice
ADHD	Shortness of Breath	Stomach/Digestive Problems
Bleeding Disorder	Stroke	Radiation Therapy
High Blood Pressure	Thyroid Problems	Joint Replacement
Low Blood Pressure	Leukemia	

Please list any conditions not covered above: ____

Is there any family history of serious medical disorders? Yes No
If Yes, please list: ____

Have you ever taken bisphosphonate medications? Yes No

Patient Dental History

Date of last dental visit: ___________________________
Month / Day / Year
Treatment at that appointment: ____

Do you have a history of severe or unusual dental problems? Yes No
If Yes, please describe: ____

Have you ever been premedicated for dental treatment? Yes No

Have you had orthodontic treatment in the past? Yes No
If Yes what treatment? ____
Where was that treatment performed? ____

Have you ever been diagnosed with or experienced any of the following? (please check all that apply)

- Cavities
- Fillings
- Bleeding Gums
- Gingivitis
- Periodontal Disease
- Periodontal Treatment
- Deep Cleaning
- Sensitive Teeth
  - To Hot
  - To Cold
  - To Sweets
  - To Sour
- Dental Pain
- Mouth Pain
- Frequent Headaches
- Clenching of your teeth
- Grinding of your teeth
- Bruxism
- Lip or Cheek Biting
- Root Canal Treatment
- Oral Surgery
- Oral Cancer
- Oral Radiation
- Snoring

Do you have any problems (clicking, pain, popping, etc) with your jaw joints? Yes No
If Yes, please describe IN DETAIL: ____
____

Is there any family history of severe or unusual dental disorders? Yes No
If Yes, please list: ____

Signatures

I (we) certify that I (we) have read, reviewed, and understand the information on the previous pages. I (we) certify that it is complete and accurate to the best of my (our) knowledge. I (we) understand that providing incomplete or incorrect information may be dangerous to my (the patient's) health.

Patient: ____ Date:_____________________________

Responsible party: ____ Date: _____________________________

(If submitting electronically, type initials above)