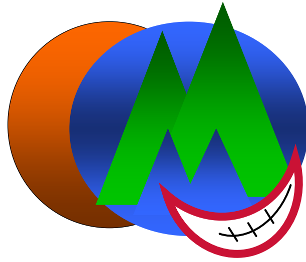
Adult



# CENTRAL MINNESOTA ORTHODONTICS

Date __________

www.cmosmiles.com

Patient's Last name_____________________ First_______________Middle _______Nickname ______________
Address___________________________City____________State____ Zip Code______ Home phone _____________
Cell phone ______________**_Birth Date**____________Age_____Sex____Interests or hobbies __________________
Employed by ___________________________________Business phone ______________________________
Would you like e-mail appointment reminders? _______ E-mail address _____________________________
Notify in case of emergency____________________________________ Phone number _______________________

**Dentist or person who referred you** ___________________________________________________________
**Attending General Dentist** __________________________________ Date of last visit _______________________
**Names of other family members treated in our office** ________________________________________________
Have you been referred here for any reason other than braces?___________________________________________
Have you been evaluated at another orthodontic office? Yes/No If yes, by whom?_____________________________

**I understand that there is no charge for this initial exam. However, if further treatment is needed, charges will apply. Please initial_________**

For the following questions circle yes, no, or don't know/understand (dk/u). The answers are considered confidential.

DENTAL HISTORY:

yes no dk/u Supernumerary or "extra" teeth?
yes no dk/u Missing any permanent teeth?
yes no dk/u Chipped or injured teeth?
yes no dk/u Teeth sensitive to hot or cold?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u Bleeding gums, bad taste or odor?
yes no dk/u Periodontal "gum" problems?
yes no dk/u Food impacted "caught" between teeth?
yes no dk/u "Gum boils", canker sores, cold sores?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Abnormal swallowing habit (tongue thrust)?
yes no dk/u History of speech problems?
yes no dk/u Mouth breathing habit, snoring, difficulty breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking or locking?

yes no dk/u Jaw pain or ringing in ears?
yes no dk/u Soreness in muscles of the face or around the ears?
yes no dk/u Difficulty chewing or opening mouth?
yes no dk/u Aware of any loose, broken or missing fillings?
yes no dk/u Any teeth irritate lip, tongue or roof of mouth?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Any relative with similar tooth or jaw conditions?
yes no dk/u Any complications with prior dental treatment?
How often do you floss_______
How often do you brush______
yes no dk/u **Do you need antibiotics prior to dental care?**

**Doctor's Notes:**

(Please complete back page)

## MEDICAL HISTORY:

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mono, tuberculosis, pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u Recent loss of weight, poor appetite?
yes no dk/u Anemia or bleeding disorder?
yes no dk/u Tires easily?
yes no dk/u Frequent headaches or sore throats?
yes no dk/u Skin disorder?
yes no dk/u Hayfever, asthma, sinus trouble?
yes no dk/u High or low blood pressure?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Drug or Food allergies? If so what kind?

yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u ADHD, behavioral problems, depression?
yes no dk/u Cardiovascular or heart problems inborn heart defects or rheumatic fever?
yes no dk/u Operations or surgical procedures?
yes no dk/u Past or current substance abuse?
yes no dk/u Taking medication, supplements or over the counter medicine? If so, which ones?

_______________________________
yes no dk/u Hospitalized for___________________
yes no dk/u Being treated by another health care professional for__________________
Date of most recent physical exam_______________

Any problem(s) not mentioned above: ____________________________________________________

**Physician's Name:**_____________________________________________

## ORTHODONTIC INSURANCE:

1) Primary orthodontic insurance company name and address ____________________________________
____________________________________________________________________________
ID # or SSN#__________________________________________ Group # ______________________
Subscriber name____________________________________ Subscriber Birth date _________________
Subscriber Employer ______________________________________________________________

2) Secondary orthodontic insurance company name and address __________________________________
____________________________________________________________________________
ID # or SSN# _________________________________________Group # ______________________
Subscriber name____________________________________ Subscriber Birth date _________________
Subscriber Employer ______________________________________________________________

Successful treatment greatly depends upon your cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any physical restrictions, handicaps or scheduling problems we should be aware of?

____________________________________________________________________________

I have read and understand the above questions. I will not hold my orthodontist or any member of Central Minnesota Orthodontics responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this office.

*_______________________________ *_______________________________ *_______________________________
Signature Date | Health History Update Signature Date | Signature of Orthodontist Date

**I have received a copy of this office's Notice of Privacy Practices (HIPAA). Please initial _______**

(2/24/08 Edition)