CAROLINA FAMILY ORTHODONTICS

Medical History - Adult

Patient's Name _____

Physician's Name _____ Date of last visit _____

Your current health is Good Fair Poor

Allergy Reactions (circle)

Latex Aspirin Nickel Jewelry Ibuprofen Other _____

Frequently experience (circle)

Headaches Fainting Teeth Grinding Vomiting

Gagging TMJ Problems Other: _____

Diagnosed or Treated (circle)

Arthritis	Asthma	Seizures	Hearing Impaired	**Rheumatic Fever
Head Trauma	Diabetes	Anemia	Hepatitis	** Heart Murmur
Teeth Trauma	Sleep Apnea	HIV/Aids	Blood Pressure	**Joint Replacement

Do you require antibiotic pre-medication for dental treatment? Yes No

Women Only

Are you taking or have ever taken a Bisphosphonate medication such as Fosomax, Boniva, Zometa, etc? Yes No

Are you pregnant or trying to become pregnant? Yes No

Medications (please list with the reason for taking the medication)

_____

_____

Dental Information

Dentist Name _____ Approx. Date of last visit _____

How often do you brush your teeth? _____ How often do you floss? _____

What is the main thing you would like to find out by coming to see us, and what would you like to change about your smile?

_____

_____

Have you seen another orthodontist about this concern? _____

Have you ever had orthodontic treatment before? _____

How did you hear about our office? _____ Referring Dentist _____ Friend, please give name _____

_____ Mailer _____ TV/Radio Ad _____ Sign _____ Facebook _____ Website/Google

_____ Other _____

I consent that to the best of my knowledge the above information is complete and correct.

_____ _____

Signature (parent or guardian if patient is a minor) Date