CAROLINA FAMILY ORTHODONTICS

Patient's Name _____ Med Hx – Under 18

Physician's Name _____

Date of last visit _____

Patient's current health is: Good Fair Poor

Allergic 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

Does the patient require antibiotic pre-medication for dental treatment? Yes No

Girls: Has menstruation begun (to determine if the patient is in a growing phase)? Yes No When? _____

Is the patient pregnant? Yes No

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

_____

_____

Dental Information

Patient's Dentist _____ Approx. Date of last visit _____

How often does the patient brush their teeth? _____ How often do they floss? _____

What is your main reason for coming to Carolina Family Orthodontics, and what would you like to change about your smile?

_____

_____

Has the patient seen another orthodontist about this concern? _____

Has the patient had any prior orthodontic treatment? _____

Does the patient have any missing teeth or extra teeth? _____

Whom may we thank for your referral to our office? _____

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

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

_____Other _____