Please Fill Out All That Apply to the Patient

Today's Date: _____

Dental History

Current dental health: ☐ Good ☐ Fair ☐ Poor

General Dentist: _____ When was the patient's last visit with their dentist? _____

Tonsils and adenoids removed? ☐ Yes ☐ No
Tenderness in jaw or jaw joint? ☐ Yes ☐ No
Extra or missing permanent teeth? ☐ Yes ☐ No

Has the patient had a previous a previous orthodontic evaluation? ☐ Yes ☐ No If yes, approximate date: _____

Does the patient have any of the following habits?

Clenching/grinding? ☐ Yes ☐ No
Nursing bottle habits? ☐ Yes ☐ No
Tongue thrust? ☐ Yes ☐ No
Lip sucking/biting? ☐ Yes ☐ No
Speech problems? ☐ Yes ☐ No
Nail/pen biting? ☐ Yes ☐ No
Mouth breathing? ☐ Yes ☐ No
Thumb/finger sucking? ☐ Yes ☐ No
Other oral habits: _____

Medical History

Current physical health: ☐ Good ☐ Fair ☐ Poor

Is patient currently under treatment by another healthcare professional? ☐ No ☐ Yes

Please check all of the following medical conditions that apply to the patient:

☐ Bleeding disorder/anemia
☐ Congenital heart defect
☐ Emphysema/glaucoma
☐ Heart attack/stroke
☐ High/low blood pressure
☐ Psychiatric problems
☐ Skeletal/bone problems
☐ Artificial joints/valves
☐ Diabetes
☐ Eye/ear/nose/throat condition
☐ Heart murmur/mitral valve prolapse
☐ HIV+/AIDS
☐ Rheumatic/scarlet fever
☐ Skin disorders
☐ Blood transfusion
☐ Breathing problems
☐ Epilepsy/seizures/fainting
☐ Heart surgery/pacemaker
☐ Hospitalizations
☐ Severe/frequent headaches
☐ Tuberculosis (TB)
☐ Cancer/chemotherapy
☐ Drug/alcohol abuse
☐ Fever blisters
☐ Hepatitis/liver problems
☐ Kidney problems
☐ Sinus problems
☐ Ulcers/colitis

Please describe any medical conditions: _____

Has puberty begun? ☐ Yes ☐ No *(For women only)* Has menstruation begun? ☐ Yes ☐ No Year started: _____

Any known drug allergies? _____

Is the patient allergic to any of the following? ☐ Latex ☐ Metal ☐ Acrylic ☐ Other _____

List any medications the patient is currently taking (including over-the-counter medicines, vitamin and herbal supplements) _____

Emergency Information

In case of emergency, who should we call? Name: _____ Phone #: _____

Relationship to patient: _____ Physician: _____ Phone #: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform Prairie Pointe Orthodontics of any changes in my medical status. I authorize Dr. Neuer's staff to perform any necessary orthodontic services that may be needed during diagnosis and treatment with my informed consent.

Signature: _____ Relationship to patient: _____ Date: _____