

MEDICAL HISTORY

Date of your last visit with a physician: _____

Please check Yes or No. If your answer is Yes, please provide details.

- Yes ☐ No ☐ Are you taking any medication currently? _____
- Yes ☐ No ☐ Are you allergic to any medication? _____
- Yes ☐ No ☐ Do you have a history of any serious illness? _____
- Yes ☐ No ☐ Have you had any surgery or hospitalization? _____
- Yes ☐ No ☐ Are you currently under the care of a physician? _____
- Yes ☐ No ☐ Have you seen a physician in the past 12 months? If yes, why? _____
- Yes ☐ No ☐ For female patients: Has menstruation begun? _____
- Yes ☐ No ☐ Is there any possibility that you are pregnant?
(Please let us know if there is any change.) _____

Please check any of the following medical conditions you have or have had in the past:

- | | | | |
|---|---|---|---|
| ☐ Abnormal bleeding / Hemophilia | ☐ Diabetes | ☐ Hepatitis / Liver problems | ☐ Pneumonia |
| ☐ Anemia | ☐ Fainting / Dizziness | ☐ Herpes | ☐ Prolonged bleeding |
| ☐ Arthritis / Joint problems | ☐ Epilepsy / Seizures | ☐ High blood pressure | ☐ Radiation / Chemotherapy |
| ☐ Asthma or hay fever | ☐ Gastrointestinal disorders | ☐ HIV / AIDS | ☐ Rheumatic fever |
| ☐ Bone disorders | ☐ Heart problems | ☐ Kidney problems | ☐ Tuberculosis |
| ☐ Congenital heart defect | ☐ Heart murmur | ☐ Nervous disorders | ☐ Tumor or Cancer |

Do you have any other medical condition not listed above? If yes, please explain: _____

DENTAL HISTORY

Date of your last dental visit: _____

General Dentist: _____

Phone: _____

What is your main concern about your teeth? _____

- | | |
|---|--|
| Yes ☐ No ☐ Do you currently have dental pain? | Yes ☐ No ☐ Have you had orthodontic treatment before? If yes, when? |
| Yes ☐ No ☐ Have you had any unfavorable reaction to dental treatment? | Yes ☐ No ☐ Has anyone in your family had orthodontic treatment? |
| Yes ☐ No ☐ Have you lost a tooth or have a broken tooth? | Yes ☐ No ☐ How would you describe your results? |
| Yes ☐ No ☐ Do you have any sores or ulcers in your mouth? | Yes ☐ No ☐ Do your teeth or jaws make noises? |
| Yes ☐ No ☐ Is any part of your mouth sensitive to temperature? | Yes ☐ No ☐ Do your teeth or jaws feel uncomfortable in the morning? |
| Yes ☐ No ☐ Is any part of your mouth sensitive to pressure? | Yes ☐ No ☐ Do you clench or grind your teeth when opening or closing your mouth? |
| Yes ☐ No ☐ Do your gums bleed when brushing? | Yes ☐ No ☐ Are you aware of clenching or grinding your teeth? |
| Yes ☐ No ☐ Do you have a habit of chewing on your fingers, nails or tongue? | Yes ☐ No ☐ Do you have frequent headaches or facial pain? |
| Yes ☐ No ☐ Do you use a mouth breathing habit? | Yes ☐ No ☐ Do you have chronic earaches or ear pain? |
| | Yes ☐ No ☐ Does the patient require additional help to follow instructions? |
| | Yes ☐ No ☐ Do you consider the patient to have special needs? |

Parent's status: Mother: _____ Father: _____

Will the patient miss school for appointments? _____

What is the patient's attitude toward receiving orthodontic treatment?

- ☐ Wants treatment
 ☐ Treatment is necessary
 ☐ Not willing, but accepts
 ☐ Uncooperative

BENEFITS AND CONSENT

The benefits of orthodontics include improved appearance, better oral health and improved function. Orthodontics improves the appearance and general function of the teeth. Teeth, gums and jaws are an important part of the body and can respond to treatment. If oral hygiene is inadequate, cavities and gum disease may occur. Discomfort in the joints and roots may occur in a small percentage of cases. Teeth change throughout our lives and dental movement may change after treatment. I have read and understand this paragraph.

I understand and acknowledge that I am financially responsible for services provided, regardless of insurance coverage.

I understand my diagnostic information and name may be used for educational and promotional purposes.

I have honestly answered the above questions and agree to inform this office of changes in my medical or dental history.

I authorize Dr. Matthew Ng and/or Dr. Patricia Tran to perform a complete orthodontic evaluation.

Signature: _____

Date: _____