Patient Name : _____DOB:_____

MEDICAL HISTORY

Physician Date of Last Visit

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____ Are you allergic to Latex or Metal?:_____

Yes No Do you have a history of a major illness?

Yes No Have you had any operations?

Yes No Have you ever been involved in a serious accident?

Yes No Have seen a physician in the last 12 months? Why?

Yes No Do you chew tobacco or smoke? If so how often? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Dizziness/Fainting	High Blood Pressure	Radiation/Chemotherapy
Anemia	Epilepsy	HIV / Aids	Rheumatic Fever
Arthritis	Gastrointestinal Disorders	Kidney problems	Tuberculosis
Asthma or Hay fever	Heart Problem	Latex Allergy	Tumor or Cancer
Bone Disorders	Heart Murmur	Nervous Disorders	Psychiatric Treatment
Congenital Heart Defect	Hepatitis/Liver problems	Pneumonia	Venereal Disease
Diabetes	Herpes	Prolonged Bleeding	Respiratory Disease

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

ADULTS

Are you currently taking or have ever taken any intravenous bisphosphonates for serious bone disorders/cancers; such as Zometa (alendronate), Aredia (pamidronate), Didronel (etidronate). Yes No if yes, describe: _____

Are you currently taking or have ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as, Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate). Yes No If yes, describe: _____

DENTAL HISTORY

What concerns you most about your teeth?

Are you self-conscious about the appearance of your teeth? Yes No

Are you presently in any dental pain? Yes No Have you ever experienced any unfavorable reaction to dentistry? Yes No

Have you ever lost or chipped any teeth? Yes No Are there any missing or extra permanent teeth? Yes No

Have there been any injuries to face, mouth, or teeth? Yes No _____

Is any part of your mouth sensitive to temperature? Where? Yes No Is any part of your mouth sensitive to pressure? Where? Yes No _____

Do your gums bleed when you brush? Yes No Has your dentist shown you how to clean your teeth? Yes No

Do you have any type of thumb or tongue habit? Yes No Are you a mouth breather? Yes No

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

Have you ever seen an orthodontist? If yes, who and when?

What is your attitude toward receiving orthodontic treatment?

Has anyone in your family received orthodontic treatment?

Do your teeth or jaws ever feel uncomfortable when you awake in the morning? Yes No Are you aware of your jaw clicking or popping? Yes No

Are you aware of clenching your teeth during the day? Yes No Have you ever been told that you grind your teeth? Yes No

Do you have "tension" headaches? Yes No Have you ever experienced chronic ringing in your ears? Yes No

Do you play any musical instruments by mouth? Yes No _____

If the patient is under age 16, height of parents? Mom_____ Dad_____

FEMALE PATIENTS ONLY

Yes No Are you pregnant?_____ (If under 18) Have you started her monthly period?: Yes No

Yes No Are you planning on becoming pregnant? _____

BENEFITS

I have read and understand the above questions. I will not hold my orthodontist, at Thousand Oaks Orthodontics, or any member of his staff 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 practice. I authorize the office of Thousand Oaks Orthodontics to take x-rays, study models and photographs as diagnostic aids to make a thorough diagnosis of the patient's orthodontic needs.

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Doctor)

NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Patient's Name _____

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgments
- Other (Please Specify)

THOUSAND OAKS
ORTHODONTICS
PRECISION SMILES