Tadej ORTHODONTICS
smiles apart

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HEALTH HISTORY

PATIENT'S NAME_____ DATE _____

NAME OF PHYSICIAN _____ LAST VISIT _____

ARE YOU UNDER THE CARE OF A PHYSICIAN?_____YES ❑ NO ❑

IF YES, FOR WHAT REASON?_____

ARE YOU CURRENTLY TAKING MEDICATION? _____YES ❑ NO ❑

IF YES, WHAT? _____

ARE YOU ALLERGIC TO MEDICATIONS? YES ❑ NO ❑ FOOD? YES ❑ NO ❑

IF YES, WHAT? _____

ARE YOU ALLERGIC TO LATEX, NICKEL (METALS), ETC.? YES ❑ NO ❑

IF YES, WHAT? _____

HAVE YOU EVER BEEN HOSPITALIZED? _____YES ❑ NO ❑

IF YES, EXPLAIN? _____

GENERAL HEALTH? EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑

DO YOU HAVE ANY DIFFICULTY BREATHING THROUGH NOSE? _____YES ❑ NO ❑

DO YOU TEND TO BREATHE THROUGH THE MOUTH WHILE SLEEPING? _____YES ❑ NO ❑

DO YOU GRIT OR GRIND TEETH DURING THE DAY OR NIGHT? _____YES ❑ NO ❑

HAVE YOU EVER HAD ANY BONE, CONNECTIVE TISSUE (COLLAGEN), OR HORMONAL ABNORMALITIES? YES ❑ NO ❑

IF YES, EXPLAIN: _____

HAVE YOU EVER HAD PROBLEMS WITH CLICKING, POPPING OR PAIN IN JAW JOINT? _____ YES ❑ NO ❑

HAVE YOU EVER HAD ANY PREVIOUS ORTHODONTIC TREATMENT? _____YES ❑ NO ❑

DENTAL HISTORY

NAME OF DENTIST _____ LAST VISIT _____

WHAT SERVICES DID YOU HAVE ON LAST VISIT: _____

DO YOU MAKE REGULAR VISITS TO DENTIST? YES ❑ NO ❑ HOW OFTEN? _____

HOW OFTEN DO YOU BRUSH? _____USE DENTAL FLOSS? _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

	YES	NO
HEART TROUBLE OR CONGENITAL HEART LESIONS	❑	❑
ASTHMA	❑	❑
SKIN RASH OR HIVES	❑	❑
KIDNEY INVOLVEMENT	❑	❑
HEPATITIS OR LIVER INVOLVEMENT	❑	❑
EPILEPSY	❑	❑
"COLD SORES" OR FEVER BLISTERS	❑	❑
MALIGNANCIES	❑	❑
HEARING PROBLEMS	❑	❑
FAINTING OR DIZZINESS	❑	❑
DIABETES	❑	❑
TUBERCULOSIS	❑	❑
RHEUMATIC FEVER	❑	❑
BLEEDING DISORDERS	❑	❑
NERVOUSNESS OR HYPERACTIVITY	❑	❑
ANEMIA	❑	❑
THYROID OR PARATHYROID DISORDERS	❑	❑
MONONUCLEOSIS	❑	❑
ARTHRITIS	❑	❑
VENEREAL DISEASE	❑	❑
STOMACH OR DUODENAL ULCER	❑	❑
LIVER DISEASE	❑	❑
EMPHYSEMA	❑	❑
HEART MURMUR	❑	❑
ARTERIOSCLEROSIS	❑	❑
HIGH OR LOW BLOOD PRESSURE	❑	❑
EXCESSIVELY SWOLLEN ANKLES	❑	❑
A STROKE	❑	❑
EMOTIONAL PROBLEMS OR TENSION	❑	❑
PSYCHIATRIC TREATMENT	❑	❑
RADIATION TREATMENT BY COBALT, RADIUM X-RAY, ETC.	❑	❑
GLAUCOMA	❑	❑
CONTACT LENSES	❑	❑
AIDS	❑	❑
BLOOD TRANSFUSION	❑	❑
IF YES, WHEN: _____		
TAKING APPETITE SUPPRESSANTS	❑	❑
IF YES, WHAT: _____		

IF YOU ARE AN ADULT FEMALE, ARE YOU NOW:

PREGNANT	❑	❑
TAKING BIRTH CONTROL	❑	❑
PRESENTLY IN MENOPAUSE (CHANGE OF LIFE)	❑	❑
PAST MENOPAUSE	❑	❑

PATIENT'S SIGNATURE: _____ DATE _____

DOCTOR'S COMMENTS: _____

_____

UPDATES (DATE & INITIAL) _____ _____ _____ _____

NO CHANGES PARENTS INITIAL _____ _____ _____ _____

Date _____

CONFIDENTIAL PATIENT INFORMATION

A B C

Patients Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____ ❒ Own ❒ Rent
Street City State Zip

Mailing Address _____ Email _____
Street City State Zip

How long at this address _____ Previous Address _____
(if less than 3 yrs) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

INSURANCE INFORMATION

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holders Employer _____

Do you have dual coverage? ❒ No ❒ Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate credit bureau reports will be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

PATIENT MOTIVATION FOR TREATMENT

Patients often request changes in their bites or faces and relief from pain or discomfort.
Please help us understand your problem by checking the following information; please be specific
(check the words more, less, forward, backward, longer, shorter, etc.):

Teeth: If your teeth could be changed, how would you like to change them?

straighten the front teeth **upper** **lower**

straighten the back teeth **upper** **lower**

make the upper front teeth **longer** **shorter**

move upper teeth **forward** **backward**

move lower teeth **forward** **backward**

make the line of the upper front teeth more level

other_____

Face: If your facial appearance could be changed, what would you change?

get rid of sag under lower jaw

move chin **forward** **backward**

move chin **left** **right** to center it

move lower lip **forward** **backward**

move upper lip **forward** **backward**

move the area around my nose **forward** **backward**

make the profile of my nose **longer** **shorter**

move the area under my eyes **forward** **backward**

make my cheekbones **larger** **smaller**

show **more** **less** of my **teeth** **gums** **-** when I smile

make my lips **closer together** **farther apart** when my teeth are touching

make my lips not touch and rollout when my teeth are touching

reduce the strain in my **chin** **lips** when I close my lips

make my face more **narrow** **wide**

reduce the **width** **fullness** of my lower jaw behind my mouth

other_____

Symptoms: If you want to reduce pain or discomfort where would it be located? Please be specific about the location; check the right side, left side or both if they apply.

- ☐ in front of my ears ☐ **right** ☐ **left**
- ☐ below my ears ☐ **right** ☐ **left**
- ☐ above my ears ☐ **right** ☐ **left**
- ☐ in my ears ☐ **right** ☐ **left**
- ☐ neck ☐ **right** ☐ **left**
- ☐ shoulders ☐ **right** ☐ **left**
- ☐ temples ☐ **right** ☐ **left**
- ☐ teeth
- ☐ sinuses
- ☐ eyes ☐ **right** ☐ **left**

other_____