MEDICAL AND DENTAL INFORMATION
PRELIMINARY INFORMATION

Patient's Name _____ (Last) _____ (First) _____ (Middle) Nickname _____ Sex _____

Date of Birth _____ (Month) (Day) (Year) Age in Years _____ School _____ Grade _____

Home Address _____ (Street No.) _____ (Street Name) Phone _____

City _____ State _____ Zip _____

Father's Name _____ Soc. Sec. No. _____ Age _____

Father's Occupation _____ (Last) (First) (Middle) Business Phone No. _____

Business Address _____ (Street No.) (Street Name) (City) (State) (Zip)

Mother's Name _____ Soc. Sec. No. _____ Age _____

Mother's Occupation _____ (Last) (First) (Middle) Business Phone No. _____

Business Address _____ (Street No.) (Street Name) (City) (State) (Zip)

Person Responsible for Account if Now Divorced or Separated _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Policy No. _____

Insurance Co. _____ Group No. _____

Insured's Employer _____

MEDICAL HISTORY

The patient's Medical and Dental History Information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Is patient in good health? ..... Yes No
2. Has there been any change in patient's general health within the past year? ..... Yes No
3. Patient's last physical examination was on _____
4. Is patient now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of patient's physician(s) is _____
6. Is patient taking any medicine(s) including non-presciption medicine? ..... Yes No
   If so, what medicines are being taken? _____
7. Has patient had any serious illness, operation or been hospitalized in the past 5 years? ..... Yes No
   If so, what was the illness or problem? _____
8. Does patient have tendency to sore throats? If yes, how often? _____
   Does patient have tendency to ear aches? If yes, how often? _____
   Has patient had Tonsils and/or Adenoids removed? If yes, when? _____
   Does patient have tendency to colds? If yes, how often? _____
9. Has patient had any injuries to the face, head or teeth? If yes, please give complete details including date(s) of occurence, nature of injury and who treated: Yes No
10. Does patient have or has patient had any of the following diseases or problems? ..... Yes No
    a. Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? ..... Yes No
    b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No
       1. Pain in chest upon exertion? ..... Yes No
       2. Ever short of breath after mild exercise or when lying down? ..... Yes No
       3. Do ankles swell? ..... Yes No
       4. Have inborn heart defects? ..... Yes No
       5. Have a cardiac pacemaker? ..... Yes No
       6. Ever had heart surgery? ..... Yes No
    c. Allergy ..... Yes No
    d. Sinus trouble ..... Yes No
    e. Asthma or hay fever ..... Yes No
    f. Fainting spells or seizures, dizziness ..... Yes No

g. Persistent diarrhea or recent weight loss ..... Yes No
h. Diabetes ..... Yes No
I. Hepatitis, jaundice or liver disease ..... Yes No
j. AIDS or HIV infection ..... Yes No
k. Thyroid problems ..... Yes No
l. Respiratory problems, emphysema ..... Yes No
m. Arthritis or painful swollen joints ..... Yes No
n. Stomach ulcer or hyperacidity ..... Yes No
o. Kidney trouble ..... Yes No
p. Tuberculosis ..... Yes No
q. Persistent cough or cough that produces blood ..... Yes No
r. Persistent swollen glands in neck ..... Yes No
s. Low blood pressure ..... Yes No
t. Sexually transmitted disease ..... Yes No
u. Epilepsy or neurological disease ..... Yes No
v. Problems with mental health ..... Yes No
w. Cancer ..... Yes No
x. Problems of the immune system ..... Yes No
y. Alcoholism or drug dependency or addiction ..... Yes No
aa. Scarlet Fever ..... Yes No
bb. Chemotherapy ..... Yes No
cc. Radiation Therapy ..... Yes No
dd. Cortisone Therapy ..... Yes No
ee. Cosmetic Surgery ..... Yes No
ff. Diabetes ..... Yes No
gg. Rheumatism ..... Yes No
hh. Epilepsy ..... Yes No
ii. Chicken Pox ..... Yes No
jj. Fever Blisters ..... Yes No
kk. Glaucoma ..... Yes No
ll. Measles ..... Yes No
mm. Mumps ..... Yes No
nn. Nervousness/Anxiety ..... Yes No
oo. Psychological treatment ..... Yes No
pp. Psychiatric treatment ..... Yes No
qq. Ulcers ..... Yes No

11. Has patient had abnormal bleeding? ..... Yes No
a. Has patient ever required a blood transfusion? ..... Yes No
12. Does patient have any blood disorder such as anemia, hemophelia, leukemia, sickle cell disease? ..... Yes No
a. Does patient bruise easily? ..... Yes No
13. Has patient ever had any treatment for a tumor or growth? ..... Yes No
14. Is patient allergic or have you had a reaction to:
a. Local anesthetics ..... Yes No
b. Penicillin or other antibiotics ..... Yes No
c. Sulfa drugs ..... Yes No
d. Barbituates, sedatives, or sleeping pills ..... Yes No
e. Aspirin ..... Yes No
f. Iodine ..... Yes No
g. Codeine or other narcotics ..... Yes No
h. Other _____ Yes No

The medical information provided is complete and correct to the best of my knowledge. I agree to inform this office of any changes in my health and of recent visits to my physician at my next visit. In addition, I authorize Dr. Contes to perform a complete orthodontic examination.

_____ _____

Date Signature

DENTAL HISTORY

GENERAL DENTAL INFORMATION

1. When was patient's last dental visit? _____
2. How frequently does patient visit his or her dentist? _____
3. The name and address of patient's dentist is: _____

_____

4. Do you anticipate a move or transfer in the near future? . . . . . Yes No
   If yes, please explain _____
5. Has patient ever had an injury to his/her head, face or neck? . . . . . Yes No

ORTHODONTIC INFORMATION

1. Has patient ever had orthodontic treatment (braces)? . . . . . Yes No
   If yes, when and by whom? _____
2. Has patient ever had an orthodontic examination, evaluation, conference or consultation? . . . . . Yes No
   If yes, when and by whom? _____

PERIODONTAL (GUM) INFORMATION

1. Have you or patient ever been told that patient has gum disease? . . . . . Yes No
   If yes, when and by whom? _____
2. Has patient ever been advised to have periodontal (gum) treatment? . . . . . Yes No
3. Has patient ever had a periodontal examination? . . . . . Yes No
   If yes, when and by whom? _____
4. Has patient ever had a periodontal gum treatment? . . . . . Yes No
   If yes, when and by whom? _____

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

1. Does patient's jaw joint(s) click, crack, pop, grate or make any other sound(s)? . . . . . Yes No
   If yes, please explain _____
2. Has patient's jaw joint(s) ever made any of the above or other sounds? . . . . . Yes No
   If yes, please explain _____
3. Does patient grind teeth? . . . . . Yes No
4. Does patient clench teeth? . . . . . Yes No
5. If patient is experiencing stress, does patient grind teeth? . . . . . Yes No
6. Does patient ever have or has patient ever had jaw soreness, jaw pain, muscle soreness (jaw area), neck soreness? . . . . . Yes No
   If yes, please explain _____
7. Does patient now or has patient previously experienced ear aches, ear pain, stuffiness in his or her ear(s), reduced hearing or loss of hearing? . . . . . Yes No
   If yes, please explain _____

continued on other side

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

8. Has patient's jaw ever "locked" open or closed? . . . . . Yes No

If yes, please explain _____

9. Has patient ever been told that patient has a TMJ or "Jaw Joint" problem? . . . . . Yes No

If yes, please explain _____

10. Has patient ever been advised to have treatment for a TMJ or "Jaw Joint" problem? . . . . . Yes No

If yes, please explain _____

11. Has patient ever had treatment for a TMJ or "Jaw Joint" problem? . . . . . Yes No

If yes, please explain _____

12. Has patient ever worn a splint or night guard appliance for any reason? . . . . . Yes No

If yes, please explain _____

13. Has patient ever been told that you have jaw arthritis? . . . . . Yes No

If yes, when and by whom _____

The dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in patient's dental health and of recent visits to patient's dentist at the next visit.

_____ _____

Date Signature