cht orthodontics of Hinsdale

TODAYS DATE:_____

PATIENT

Name: _____**Prefers to be called :**_____

DOB:_____**Age:**_____

Home Address: _____

Contact Phone: _____

Employer: _____ **Occupation:** _____

Email: _____

Marital Status: Married Divorced Separated Single Widowed

Spouse's Name: _____

DENTAL INSURANCE

Insurance Coverage: yes no **Insurance Co:** _____

Insured's Name: _____ **Insured DOB:** _____

Group #: _____ **SSN/ID**: _____ **Phone #:** _____

ADDITIONAL INFORMATION

Family Dentist: _____ **Date of Last Cleaning:** _____

Family Physician: _____ **Date of Last Check-up:** _____

How did you hear about our office? _____

What are your main concerns regarding your teeth? _____

Have you had previous orthodontic treatment? _____

If yes; please provide approximate dates, summary of treatment, retainer types and dates worn : _____

_____

How would you like us to contact you? Call Email Text

PLEASE ANSWER HEALTH HISTORY QUESTIONS ON THE BACK SIDE

	Yes	No
1 . Are you under a doctor's care at the present time?		
2. Are you presently taking any medication regularly?		
3. Have you ever been told you have a heart condition		
Do you require any premedication before dental appointments?		
4. Have you ever been told that your blood pressure is too high or too low?		
5. Have you ever had rheumatic fever or rheumatic heart disease?		
6. Do you bleed excessively following a cut or other injury?		
7. Are you allergic to any food, drug, or medicine?		
If so, please list :		
8. Do you have other allergies?		
9. Have you ever been treated for diabetes?		
10. Have you ever been treated for epilepsy?		
11. Have you ever been diagnosed with or treated for ADD, ADHD, OCD, Bipolar Disorder?		
12. Have you ever taken Cortisone, ACTH, or other steroid drug?		
13. Have you ever had a blood disease?		
14. Have you ever had a bone disease, or more than one bone fracture?		
15. Have you ever had a tumor or cancer?		
16. Have you ever had surgery?		
17. Have you had your tonsils and adenoids removed?		
18. Have you ever had a disease of the eyes, ears, nose, or throat?		
19. Have you ever experienced prolonged bleeding following a tooth extraction or oral surgery?		
20. Have you ever experienced difficulty when dental anesthetics (Novocain) were administered?		
21. Have you been diagnosed with having AIDS or AIDS-Related Complex?		
22. Have you had any serious illness other than those mentioned?		
23. Did you have any physical or genetic anomalies at birth?		
24. Have you had any accidents or injuries relating to your face, teeth , or head?		
25. Did you ever suck your thumb or fingers?		
26. Have you ever had any other oral habits (nail biting, lip biting, cheek biting, etc.)?		
27. Do you grind or clench your teeth?		
28. Did your primary ("baby") teeth erupt on time (6-9 months of age)?		
29. Has a dentist ever extracted any of your primary or permanent teeth?		
30. Have you ever had:		
a. Pain in your jaw joint when opening, chewing, or yawning?		
b. Limited jaw movement?		
c. Clicking or popping noises in your ears while chewing?		
d. Your jaw get stuck open or closed?		

If any of the above questions are checked yes, please explain next to the question.

Signature _____