PSJ ORTHODONTICS PATIENT
Medical History Form

Date: _____

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____ Nickname: _____

Birthdate: _____ Gender: _____ E-mail: _____

Address: _____ Main Phone: _____

_____ Cell Phone: _____

Family/ Friends in PSJ: _____ Referred by: _____

Sports/ Hobbies: _____

School: _____ Grade: _____

RESPONSIBLE PARTY INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Relationship to patient: _____ E-mail _____

Address (if different from patient)

_____ Cell: _____

_____ Work Phone: _____

Employer: _____ SSN: _____

Second Parent or Guardian

First Name: _____ Middle Initial: _____ Last Name: _____

Relationship to patient: _____ E-mail _____

Address (if different from patient)

_____ Cell: _____

_____ Work Phone: _____

Employer: _____ SSN: _____

DENTAL INSURANCE INFORMATION

-Insurance Company 1: _____ Address: _____

Policy Holder's Name: _____ Employer: _____

Birthday: _____ Relationship to Patient: _____ ID: _____ Group: _____

-Insurance Company 2: _____ Address: _____

Policy Holder's Name: _____ Employer: _____

Birthday: _____ Relationship to Patient: _____ ID: _____ Group: _____

DENTAL HISTORY

Name of Dentist: _____ Last Dental Visit: _____

Address: _____ Main Orthodontic Concern: _____

_____ _____

Has the patient previously had an orthodontic consultation or treatment?

YES ☐ NO ☐ If 'Yes', when? _____

Does the patient pre-medicate prior to dental visits? YES ☐ NO ☐

Main Orthodontic Concern: _____

Please indicate whether or not the patient has had any of the conditions listed below either *now or in the past*.

Condition	YES	NO
Speech problem/ therapy		
Injury to face, jaw, teeth or mouth		
Frequent headaches		
Teeth sensitivity to hot or cold		
Mouth breathing		
Apprehension about dental care		
Bleeding gums		
Clench or grind teeth		
Chipped or injured permanent teeth		
Previous periodontal (gum) treatment		
Snores during sleep		
Jaw fractures, cysts, mouth infections		
Frequent canker sores or cold sores?		
Thumb or finger habit (if yes, age when stopped _____)		

Explanations and other dental concerns:

TMJ HISTORY

Condition	YES	NO
Have you ever been treated for TMJ?		
Do you experience soreness in the muscles of your face or around your ears?		
Do you have pain, tenderness or noise in your jaw?		
Do you have a history or jaw joint problems?		
Do you notice clicking or popping in your jaw joint?		

Explanations and other TMJ concerns:

MEDICAL HISTORY

Physician's Name	QUESTION	YES	NO
Address	Have there been any changes in health in the past 5 years?		
Date of last physical?	Is the patient under a physician's care (other than routine)? If yes, for what?		
List any drug medications patient is currently taking (including non-prescription)	Has patient had serious injury/ hospitalization in the last 5 years?		

ALLERGIES OR DRUG REACTIONS

DRUG	YES	NO
PENICILLIN/ ANTI-BIOTICS		
SULFA DRUGS		
CODEINE/ NARCOTICS		
ASPIRIN/ IBUPROFEN/ ACETOMENOPHIN		
LATEX		
METAL		
PEANUTS		

List any other allergies or sensitivities the patient may have:

Please indicate whether or not the patient has had any of the conditions listed below either *now or in the past*.

CONDITION	YES	NO
Heart murmur		
Damaged or artificial heart valves		
Congenital heart defect		
Heart attack/ Stroke		
Hypertension/ Hight Blood Pressure		
Liver disease/ Jaundice/ Hepatitis		
Diabetes		
Prolonged bleeding/ Transfusion		
HIV/ AIDS		
Anemia/ blood disorder		
Asthma		
Tonsils Removed		
Adenoids Removed		
Sinus trouble		
Arthritis/ Joint problems		
Bone disorders/ loss		
Seizures/ Epilepsy/ Neurological disease		
Emotional problems		
Growth problems		
Is the patient pregnant?		
Does the patient take bisphosphonates (Fosamax or Boniva)		

Is there anything else we need to know about the patient's medical history? Explain any questions answered with a 'yes'.

UNDER 18

Height	
Weight	
Has patient begun puberty?	
Has patient grown in the last year?	
Has the patient's shoe size changed in the last year?	
Girls: Has menstruation begun?	
Boys: Has voice changed or facial hair come in?	
Has either biological parent had orthodontic treatment?	

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of their staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform PSJ Orthodontics.

Signature: _____ Date: _____

Relationship to patient: _____