LITTLE SMILES DENTAL

3469 W. BOYTON BEACH BLVD. SUITE 20
BOYTON BEACH, FLORIDA 33436
TEL (561)-736-8755
FAX (561)-736-3996

DATE: _____

PATIENT'S NAME: _____ NICKNAME: _____ SEX: _____

AGE: ___ BIRTHDATE:_____ MARITAL STATUS: _____ HEIGHT:____ WEIGHT: _____

PARENT/GUARDIAN/SPOUSE (NAME) _____
First Middle Last

STREET ADDRESS: _____ PHONE: _____

CITY AND STATE: _____ ZIPCODE: _____

FAMILY DENTIST: _____ FAMILY PHYSICIAN: _____

DENTAL INSURANCE FOR ORTHODONTICS? _____ POLICY#: _____

OCCUPATION OF PARTY WITH INSURANCE BENEFITS: _____

WHOM SHOULD WE THANK FOR

REFERRING YOU TO OUR OFFICE? _____

HEALTH HISTORY

	Yes	No
Are you in good health?	☐	☐
Are you now under the care of a physician?	☐	☐
Have you had excessive bleeding requiring special treatment?	☐	☐
Do you have any known drug reaction?	☐	☐
Prior Major Surgery or Hospitalization _____	☐	☐
Date of last medical examination _____	☐	☐
Are you taking drug or medicine?	☐	☐
Type _____ amt. _____ frequency _____		
_____		
_____		
_____		
_____		
_____		

	Yes	No
Have you had trench-mouth?	☐	☐
Have you had periodontal treatment?	☐	☐
Are you allergic to or have you reacted adversely to:		
Local Anesthetics ("Novocaine")?	☐	☐
Penicillin or other Antibiotics?	☐	☐
Sulfa Drugs?	☐	☐
Barbiturates, Sedatives, Sleeping Pills?	☐	☐
Aspirin?	☐	☐
Epinephrine?	☐	☐
Other Drugs?	☐	☐
Women: Are you pregnant?	☐	☐
Are you taking Birth Control Pills?	☐	☐

If you have had any of the following, please Circle & Date:

Heart failure	Heart Surgery	Diabetes	Hepatitis A (Infectious)
Heart Disease or Attack	Artificial Joint	Cancer	Hepatitis B (Serum)
Stroke	Respiratory Disorders	Leukemia	Yellow Jaundice
Heart Murmur	Emphysema	Arthritis	Drug Addiction
Rheumatic Fever	Tuberculosis	Rheumatism	Hemophilia
Congenital Heart Lesion	Asthma	Cortisone Medicine	Sexually Transmitted Diseases
Scarlet Fever	Hay Fever	Sickle Cell Disease	(Syphilis, Gonorrhea, Herpes)
Artificial Heart Valve	Sinus Trouble	Bruise Easily	Epilepsy or Seizures
Heart Pacemaker	Allergies or Hives	AIDS	Fainting or Dizzy spells
		Psychiatric Therapy	

Do you have any disease, condition or problem not listed above? _____

_____

ORTHODONTIC HISTORY

Please answer the following questions, as they are very important to completing your health history. These questions will pertain to the new orthodontic patient.

1. Headaches …..... YES NO
2. Dizziness …..... YES NO
3. Ringing, Buzzing or other sounds in the ears …..... YES NO
4. A feeling of fullness in the ears or sinuses …..... YES NO
5. Numbness or tingling anywhere for a duration of time …..... YES NO
6. Backaches (upper or lower) …..... YES NO
7. Neck-aches …..... YES NO
8. Difficulty in opening or closing your mouth …..... YES NO
9. Clicking sounds from your jaw joint …..... YES NO
10. Pain from the jaw joint …..... YES NO
11. Pain in the facial muscles …..... YES NO
12. Pain in the upper or lower teeth …..... YES NO
13. Constant or recurring sore throat …..... YES NO
14. Inability to open and close your mouth …..... YES NO
15. Pain around the eyes or visual problems …..... YES NO
16. Frequently encounter stressful situations at home or work …..... YES NO
17. Have you ever been involved in an accident? …..... YES NO
    If you answered YES please give the date _____
18. Have you ever received any previous orthodontic treatment? …..... YES NO
    If YES, please list the prior doctor's name _____

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE SYMPTOMS, THEN, PLEASE COMPLETE THE FOLLOWING:

Have you ever been treated for these symptoms ..... YES NO
Has the treatment been successful? …..... YES NO
Are you currently taking any medications for these symptoms? …..... YES NO
If YES, please list the medications _____
When did you first become aware of these symptoms? _____
Please list the name(s) of the doctor(s) that you have consulted or have treated you for these symptoms:

_____ MD/DDS PHONE _____
_____ MD/DDS PHONE _____
_____ MD/DDS PHONE _____

19. Are you or do you wear contact lenses? …..... YES NO
20. Please list your main reasons for seeking orthodontic treatment _____
    _____
    _____

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED UNLESS PROIR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

_____
Signature of Parent, Guardian or Spouse