Ortholine Family Dentistry

Name:_____Birthday:_____ SS#_____

Phone Number:_____ Cell Phone: _____

Address_____ City:_____ Zip:_____

Status: _____ Minor, ____ Single, _____Married, _____Divorced, _____Widow, _____ Separated

Guardian:_____ Phone:_____

Primary Physician:_____ Phone:_____

Emergency contact:_____ Phone:_____

Medical History: Do you have or have had any of the following?

Artificial joints: ____YES ___NO

Rheumatoid arthritis ____YES___NO

Rheumatic fever ____YES ___NO

Scarlet Fever ____YES ____NO

Glaucoma ____YES____NO

Headaches ___YES ___NO

Cortisone treatment ___YES ___NO

Epilepsia/convulsion ____YES ___NO

Diabetes ____YES ___NO

Blood Pressure ____HIGH ___LOW

Circulatory disorders ___YES ___NO

Stroke ___YES ___NO

Prolonged bleeding ___YES ___NO

Heart problems ____YES ___NO

Mitral Valve prolapse ___YES ____NO

Artificial heart valve ____YES ____NO

Heart murmur ___YES ___NO

Cancer ____YES ____NO

Radiation therapy ___YES ___NO

Shortness of breath ___YES ___NO

Respiratory problems ____YES ___NO

Asthma ____YES___NO

Shortness of breath ___YES ___NO

Tuberculosis ____YES ___NO

Kidney disease ____YES ____NO

Thyroid imbalance ___YES ___NO

Tobacco habit ___YES ___NO

Stomach ulcers ___YES ___NO

Liver disease ___YES ____NO

Hepatitis ____YES ___NO

Blood disease ___YES ___NO

Aids/Hiv+ ____YES ___NO

Herpes ____YES ____NO

Syphilis ____YES ____NO

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Angina ____YES ____NO **Psychiatric care ___YES ___NO**

Please note any other medical conditions not mentioned (any illnesses or surgeries):

_____

Pregnant? ___YES ___NO **Breastfeeding? ____YES ___NO**

List any medications that you are taking:_____

List any allergies:_____

DENTAL HISTORY

Do your gums bleed when flossing or brushing? ____YES ____NO

Are your teeth sensitive to hot, cold, sweet, or acid? _____YES ____NO

Do you have any dental plan? ____YES ____NO

Do you have any sores or lumps on or near your mouth? ____YES ____NO

Do you clench or grind your teeth ? ____YES ____NO

Does your jaw click and pop? _____YES _____NO

Do you have any pain in your jaw or have headaches? ____NO ____YES

Do you need to take antibiotic before dental treatment? _____NO _____YES

I certify that I have read and understand everything that is on this sheet with my best know ledge the questions I answered correctly and I know that if I have provided incorrect information it could be harmful to my health. I authorize the dentist to do any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents entails certain risks. I authorize the dentist to give me my treatment, x-rays and any other information about me or a child of mine to a third person or health insurance. I give insurance authorization to pay the direct dentist that the insurance could pay less than the fractured and not covered by the insurance. It will be a responsibility for me or my children's arrangements.

_____ _____

Patient or Guardian Signature Date

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