Dental History

Dentist: _____ Date of last cleaning: _____

Address: _____ Phone: _____

How often do you brush? _____ floss? _____

Check any boxes that apply to the patient:

☐ ever sucked a thumb or finger? Until what age: _____

☐ previous orthodontic care
☐ clicking or popping jaw
☐ grinding or clenching teeth
☐ jaw pain
☐ sore facial muscles
☐ jaw/facial injuries
☐ dental/tooth injuries
☐ loose teeth or broken fillings
☐ sores or growths in the mouth
☐ bleeding gums
☐ sensitivity to hot or cold
☐ mouth breathing

Please describe any dental conditions checked above: _____

_____

Do you have any dental problems not listed above? ☐ Yes ☐ No

If yes, please describe: _____

Medical History

Check any boxes that apply to the patient:

☐ currently under a physician's care? Describe: _____

☐ currently taking medications? Describe: _____

☐ any allergies to medication? Describe: _____

☐ any contact allergies (latex, nickel, etc.)? Describe: _____

☐ congenital heart problems
☐ heart murmur
☐ rheumatic fever
☐ tuberculosis
☐ abnormal bleeding
☐ high/low blood pressure
☐ diabetes
☐ HIV/AIDS
☐ hepatitis
☐ liver problems
☐ kidney problems
☐ arthritis
☐ epilepsy/seizures
☐ fainting spells
☐ asthma
☐ sinus trouble
☐ frequent headaches
☐ tonsils & adenoids removed
☐ smoke/chew tobacco
☐ psychiatric care
☐ currently pregnant

Please describe any medical conditions checked above: _____

_____

Has your physician recommended pre-medication with antibiotics for routine dental visits? ☐ Yes ☐ No

Do you have any medical problems not listed above? ☐ Yes ☐ No

If yes, please describe: _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used by Matthew D. Jones, DDS to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the office of Matthew D. Jones, DDS.

I authorize my insurance company to pay to Matthew D. Jones, DDS all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Matthew D. Jones, DDS to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____