Discover your best smile

Today's Date: ______________________

Patient Name: ______________________ Patient Age: ______________________

MEDICAL HISTORY

Physician: ______________________

Please circle YES or NO and provide relevant details.

YES NO Are you currently taking any medication? ______________________
YES NO Are you allergic to any medications, metals, or latex? ______________________
YES NO Do you have a history of a major illness? ______________________
YES NO Have you had any major operations? ______________________
YES NO Have you ever been involved in a serious accident? ______________________

Please circle any of the medical conditions below that you have or have had.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Nervous Disorder
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Rheumatic Fever
Asthma/Hay fever	Gastrointestinal Disorders	HIV/AIDS	Tuberculosis
Bone Disorders	Heart Problems	Kidney problems	Tumor/Cancer
Congenital Heart Defect	Heart Murmur	Latex Allergy	

DENTAL HISTORY

Dentist: ______________________

Approx Date of Last Dental Visit: ______________________

What concerns you most about your teeth? ______________________

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YES NO Are you presently in any dental pain? ______________________
YES NO Have you ever lost or chipped any teeth? ______________________
YES NO Have there been any injuries to your face, mouth or teeth? ______________________
YES NO Is any part of your mouth sensitive to temperature or pressure? ______________________
YES NO Do your gums bleed when you brush? ______________________
YES NO Do you have any type of thumb or tongue habit? ______________________
YES NO Are you a mouth breather? ______________________
YES NO Have you had previous orthodontic treatment? ______________________
YES NO Are you aware of your jaw clicking or popping? ______________________
YES NO Are you aware of clenching your teeth during the day? ______________________
YES NO Have you ever been told that you grind your teeth? ______________________

Please list your hobbies or interests. ______________________

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I have answered the above questions to the best of my ability and agree to inform this office of any changes in my medical and dental history. In addition, I authorize Dr. Jason Lenk to perform a complete orthodontic evaluation.

Signature of Patient or Guardian: ______________________ Date: ______________________

Printed Name: ______________________