LENK ORTHODONTICS
JASON LENK, D.M.D.

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	Congenital Heart Defect	Heart Problems/Murmurs	Latex Allergy
ADHD	Diabetes	Hepatitis/Liver problems	Nervous Disorder
Arthritis	Dizziness	Herpes	Prolonged Bleeding
Asthma/Hay fever	Downs Syndrome	High Blood Pressure	Rheumatic Fever
Autism	Epilepsy	HIV/AIDS	Tuberculosis
Bone Disorders	Gastrointestinal Disorders	Kidney problems	Tumor/Cancer

DENTAL HISTORY

Dentist: _____
Approx Date of Last Dental Visit: _____
What concerns you most about your teeth? _____

_____

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: _____

_____

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: _____