

Centre Orthodontics - Dr. Pnina Tepper-Adler

Medical and Dental history

To be signed by patient over 18 or parent/guardian

Name of Patient _____

Date _____

Are you healthy? _____ yes/no

Have you ever been hospitalized? When and why? _____ yes/no

Are you taking any medication? _____ yes/no

Are you under any medical treatment _____ yes/no

Do you suffer or have you suffered from any of the following conditions:

Rheumatic Fever _____ yes/no

Hepatitis _____ yes/no

Diabetes _____ yes/no

Allergies, if yes to what? _____ yes/no

Hypersensitivity to medication? Specify _____ yes/no

Asthma or Hay fever _____ yes/no

Heart disease, murmurs, congenital heart defects _____ yes/no

Respiratory disorders _____ yes/no

Hormonal disorders _____ yes/no

Liver disorders _____ yes/no

Bone disorders _____ yes/no

Tuberculosis _____ yes/no

Kidney disorders _____ yes/no

Convulsions _____ yes/no

Bleeding disorder _____ yes/no

Neurological disorder _____ yes/no

Other- specify _____ yes/no

Have you experienced any of the following:

Difficulty in breathing through your nose _____ yes/no

Injury to the face, jaws or teeth? If yes when and where? _____

_____ yes/no

Tooth clenching or grinding _____ yes/no

Recurrent head/neck/shoulder pain _____ yes/no

Pain in jaw joints? R/L _____ yes/no

Clicking or cracking in jaw joints? R/L _____ yes/no

Have you had any teeth extracted permanent or deciduas? _____ yes/no

Have you had any orthodontic treatment in the past _____ yes/no

Have you sucked a dummy or finger? _____ yes/no

Have you sucked a dummy or finger beyond age 4 ? _____ yes/no

Do you bite your nails? _____ yes/no

Name of parent/Guardian for patient under 18 years _____

Signature of patient over 18/parent/Guardian _____

Date _____

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Patient information sheet

Patient information:

Title: Mr / Mrs / Miss / Ms / Other (please circle) if other please specify _____

Given Name: _____

Surname: _____

Preferred Name: _____

Gender: Male / female (please circle)

Date of Birth: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Address: _____

_____ Post Code _____

Name of your General Dentist _____

Information on first party responsible for fees

Title: Mr & Mrs/Mr/Mrs/Miss/Ms/Other (please circle) if other specify _____

Responsible party Given Name: _____

Responsible party Surname: _____

Gender: Male / Female (please circle)

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Address: _____

_____ Post Code _____

Email address: _____

Relationship to patient: Self/Father/Mother/Brother/Sister/Other _____ (please circle)

Information on Second party responsible for fees

Title: Mr & Mrs/Mr/Mrs/Miss/Ms/Other (please circle) if other specify _____

Responsible party Given Name: _____

Responsible party Surname: _____

Gender: Male / female (please circle)

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Address: _____

_____ Post Code _____

Email address: _____

Relationship to patient: Self/Father/Mother/Brother/Sister/Other _____ (please circle)

Patient concerns:

What are your primary orthodontic concerns?

General appearance of front teeth _____ upper/lower

Straighten crowded teeth _____ upper/lower

Close spaces between the teeth _____ upper/lower

Move teeth back _____ upper/lower

Upper teeth protruding _____ upper/lower

Poor bite _____ yes/no

Inability to eat certain foods _____ yes/no