DATE _____

BRONSKY ORTHODONTICS, P.C.

Welcome to our orthodontic practice.

PATIENT DENTAL/MEDICAL HISTORY

PATIENT NAME _____

PATIENT DATE OF BIRTH _____

AGE _____

FAMILY DENTIST _____

DENTIST ADDRESS _____

Date of last dental checkup _____ Dental Checkups: Once/Year Twice/year Only if Urgent Never

Has the patient ever had any unusual dental experiences? Y or N
Specify: _____
Have any teeth been injured due to accidents or blows to the mouth? Y or N

DOES THE PATIENT: Snore? Y or N Wake up because of breathing difficulty? Y or N
Breathe through mouth? Y or N Have frequent colds? Y or N
Chewing or swallowing difficulties? Y or N Frequent sore throats, tonsillitis? Y or N

Has the patient been treated by an allergist or ear, nose and throat specialist? Y or N
By Whom? _____ Tonsils removed _____ Adenoids removed _____

Has the patient ever received or been referred for speech correction? Y or N
If "YES," date _____ Therapist _____ Location _____

HABIT HISTORY: Thumb sucking until age _____ Finger sucking until age _____
Lip biting or sucking Y or N Grinding and/or clenching of teeth Y or N (am____ pm ____)

Attitude toward orthodontic treatment _____
Is the Patient/Parent aware of any orthodontic problems? Y or N

Patient interest in orthodontic treatment: (circle) Desires Treatment Undecided
Will Undergo Treatment if Necessary Uncooperative

Orthodontic consult prompted by: Patient____ Dentist____ Mother____ Father____ Spouse____
Sibling____ Physician____ Friend____ Other_____

Reason for seeking consultation _____

Primary problem or chief concern _____

What is expected of orthodontic treatment? _____

Has patient had previous orthodontic consult or treatment? Y or N
Date _____ Doctor _____
Other family members with similar orthodontic condition: Father Mother Brother Sister Other

Additional Comments:

MEDICAL HISTORY

PATIENT NAME _____

Patient's General Health: Excellent Good Fair Poor
Name and Address of Physician:

_____

_____

Is the patient currently being treated by a Physician? Y or N Specify if Yes _____

Is the patient currently taking any medications? Y or N Specify if Yes _____

Is patient currently taking any bisphosphonate medication? (for example, Fosomax) Specify if Yes _____

_____

Is the patient allergic to any medications or substances? Y or N Specify if Yes _____

Has the patient ever had an unusual reaction to analgesics (aspirin, Advil, etc)? Y or N
Specify if Yes _____

Is the patient prone to prolonged bleeding (i.e. following extractions) Y or N
Is the patient pregnant or is pregnancy suspected? Y or N
Does the patient have frequent headaches? Y or N
Does the patient have pain or clicking in jaw joints? Y or N

Has the patient been treated or told he/she has any of the conditions below:

Heart Disease	Y	N	Kidney Problems	Y	N
Rheumatic Fever	Y	N	Venereal Disease	Y	N
Heart Murmur	Y	N	AIDS	Y	N
Prolapsed Mitral Valve	Y	N	Hepatitis	Y	N
Congenital Heart Lesions	Y	N	Jaundice or Liver Disease	Y	N
High Blood Pressure	Y	N	Do you currently have a dentist?	Y	N
Low Blood Pressure	Y	N	Inflammatory Rheumatism	Y	N
Artificial Heart Valve	Y	N	Sinus Trouble	Y	N
Premedication needed for Dental Work	Y	N	Persistent Cough	Y	N
Organ Transplant	Y	N	Arthritis	Y	N
Joint Replacement	Y	N	Stroke	Y	N
Diabetes	Y	N	Anxiety or Emotional Problems	Y	N
Ulcers	Y	N	Glaucoma	Y	N
Endocrine Problems	Y	N	Herpes (cold sores, fever blisters)	Y	N
Lung Disease	Y	N	Hives, Skin Rash	Y	N
Epilepsy	Y	N	Fainting Spells or Seizures	Y	N
Anemia	Y	N	Cancer	Y	N
Hearing Disorder	Y	N	Asthma or Hay Fever	Y	N
Latex Sensitivity	Y	N	Metal Sensitivity	Y	N

Is there any other health information that we should know about? Y or N
Specify if Yes _____

_____ _____ _____
Signature of person completing form Relationship to patient Date (Rev. 10/08)