Johnson Orthodontics

TAD. T. JOHNSON • DDS, MS

Medical History

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please Circle Yes or No (if Yes, please fill in details)

Yes No Is the patient taking any medication? Please list: _____
Yes No Is the patient allergic to any medication or other allergies? Please list: _____
Yes No History of a major illness? Please list: _____
Yes No Has the patient had any operations? Please list: _____
Yes No Has the patient ever been involved in a serious accident? _____
Yes No Has the patient seen a physician in the last 12 months? Why? _____

Female Patients Only:

Yes No Has menstruation started? When? _____
Yes No Is the patient pregnant? Due Date? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	**Congenital Heart Defect**	**Heart Problems**	**HIV/Aids**	**Radiation/Chemotherapy**
Anemia	**Diabetes**	**Heart Murmur**	**Kidney Problems**	**Rheumatic Fever**
Arthritis	**Dizziness**	**Hepatitis/Liver Problems**	**Nervous Disorders**	**Tuberculosis**
Asthma or Hayfever	**Epilepsy**	**Herpes**	**Pneumonia**	**Tumor or Cancer**
Bone Disorders	**Gastrointestinal Disorders**	**High Blood Pressure**	**Prolonged Bleeding**	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

General Dentist _____ Date of Last Visit _____
What concerns you most about patient's teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Have you been informed of any missing or extra permanent teeth? _____
Yes No Have you been informed of periodontal disease? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Height of parents? Mom _____ Dad _____
Yes No Are you aware that some appointments will be during school hours?

Benefits

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical history. In addition, I authorize Dr. Johnson to perform a complete orthodontic evaluation.

Signature: _____ Date: _____