DRS ENSOR JOHNSON & LEWIS

Adult Orthodontics

Date:_____

Personal History:

Name:_____Date of Birth:_____Cell Phone #:_____

Home Address:_____City/State/Zip:_____

Dentist:_____Physician:_____Home Phone:_____

How did you hear about us?_____

Email Address:_____

Employer:_____Position:_____Work Phone#:_____

Do you have Orthodontic Insurance? Yes___No___If Yes, Name of Insurance Carrier:_____

Has the patient ever had any orthodontic consultation or treatment? Yes___No___

If Yes, please describe:_____

Names/Relationships of any family members that have received orthodontic care:_____

_____

Medical Health History:

Please check any of the following for which you have been treated and comment if necessary:

___Adenoids	___Anemia	___Anxiety	___Arthritis	___Asthma	___Bone Disorders
___Depression	___Diabetes	___Endocrine Disorders	___Epilepsy	___Fainting or Dizziness	___Hepatitis
___Poor Health	___Prolonged Bleeding	___Rheumatic Fever	___Tuberculosis	___Other	

If Other, please explain:_____

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Do you have a tendency to colds? Yes__No__ Sore throats? Yes____No___ Ear Infections? Yes__No___

Weight:_____lbs Height:_____Allergies:_____

Have Tonsils or Adenoids been removed? Yes_____No_____If Yes, at what age?_____

Any broken bones? Yes____No_____ If Yes, did they heal satisfactorily? Yes____No____

Any Psychological counseling? Yes__No__

Have you ever had any reaction to a drug or medication? Yes__No__If Yes, please describe below: _____

_____

To the best of your knowledge, are you in good health? Yes__No__

If you are under the care of a physician for any condition or is taking any medications, please explain and list:

_____

_____

Dental History:

Have you ever had any injuries to the face? Yes____No____ Mouth or teeth? Yes__No__

Are you a mouth breather?_____ While asleep?_____ While awake?_____

Have you ever had any teeth removed at any time by a dentist? _____Which teeth?_____

Do you grind your teeth? Yes_____No_____Bite your lip excessively? Yes____No_____

Have you ever been informed of any missing or extra permanent teeth?_____

Any pain in or near the ears? Yes___No_____ Right____Left____Both_____

Any clicking or discomfort in the jaw joint near the ears? Yes___No_____ Right____Left____Both_____

In your own words, what would you like us to accomplish? _____

_____

Patient Name:_____

Patient Signature:_____