Dental History

M. Gabrielle Thodas, D.D.S., M.S.D.

When were you last seen by the dentist? ________________

- ☐ Yes ☐ No Are you taking any pills or medications for dental reasons?
- ☐ Yes ☐ No Have there been any unusual reactions to dental medications?
- ☐ Yes ☐ No Has the patient had any unfavorable reaction to dental treatment?
- ☐ Yes ☐ No Has that patient seen a periodontist, endodontist, or oral surgeon?
- ☐ Yes ☐ No Has the patient had previous orthodontic treatment or consultation?
- ☐ Yes ☐ No Has any family member had orthodontic treatment?
- ☐ Yes ☐ No Has the patient had any teeth extracted? Why? ________________
- ☐ Yes ☐ No Has the patient ever injured or broken any teeth? When and what happened? ________________
- ☐ Yes ☐ No Has the patient ever injured the head or face? When and what happened? ________________
- ☐ Yes ☐ No Does that patient have any missing or extra teeth?
- ☐ Yes ☐ No Does the patient have any trouble with eating, chewing, or swallowing?
- ☐ Yes ☐ No Does the patient suck their thumb, fingers. tongue, blanket, or pacifier? (circle which)
- ☐ Yes ☐ No Does the patient have any speech problems?
- ☐ Yes ☐ No Does the patient have any dental or face pain?
- ☐ Yes ☐ No Does the patient's jaw joint make noises or hurt on opening, closing, or chewing?
- ☐ Yes ☐ No Does the patient clench or grind?
- ☐ Yes ☐ No Does the patient normally breathe with the lips apart?
- ☐ Yes ☐ No While asleep?
- ☐ Yes ☐ No Is the patient aware of any swellings or growths in the mouth or face?
- ☐ Yes ☐ No Does the patient have negative or resistant feelings about orthodontic treatment?
- ☐ Yes ☐ No Is the patient especially worried about orthodontic treatment?
- ☐ Yes ☐ No Is the patient dissatisfied with the appearance of their teeth?
- ☐ Yes ☐ No Does the patient play a musical instrument? Which one? ________________
- ☐ Yes ☐ No Is there any other information we should know? ________________

Medical History

Who is the patient's physician? ________________ Date of last visit ________________

- ☐ Yes ☐ No Has the patient seen an ENT specialist, endocrinologist, neurologist, allergist, hematologist, cardiologist, psychiatrist, or plastic surgeon? (if yes, circle all that apply)
- ☐ Yes ☐ No Is there a current medical problem?
- ☐ Yes ☐ No Is the patient taking any pills, medications, or drugs?
- ☐ Yes ☐ No Has the patient had any unusual reaction to any medication?

What is the patient allergic to? ________________

- ☐ Yes ☐ No Has the patient ever had an injury to the head, face or mouth?
- ☐ Yes ☐ No Has the patient ever had a serious illness?
- ☐ Yes ☐ No Has the patient ever had surgery or been hospitalized?
- ☐ Yes ☐ No Have there been any unusual growth patterns noted?
- ☐ Yes ☐ No Are there any congenital (that the patient was born with) problems?

Has the patient ever been diagnosed or treated for the following? (circle those that apply):

Diabetes	Liver Problem	Epilepsy	Tonsillitis	Tuberculosis
Fainting	Breathing Problem	Hepatitis	Rheumatic Fever	Stomach Ulcers
Arthritis	Prolonged Bleeding	Jaundice	Cerebral Palsy	Cancer
Anemia	Bone Disease	AIDS or HIV+	Multiple Sclerosis	Low Blood Pressure
Heart Trouble	Thyroid Problem	Asthma	Sickle Cell Anemia	Emotional Problems

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

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Parent or Guardian's Signature Date