Bentele Orthodontics inner-smiles.com

CONFIDENTIAL PATIENT HISTORY

DATE _____/_____/20___

Last:_____, First_____, MI:___

DENTAL HISTORY

Check √ if you have at present or past dental history of any of the following

	Missing teeth		Frequent headaches or ear ringing		TMJ problems (jaw joint)
	Teeth knocked loose/fractured		Facial trauma or surgery		Teeth grinding or jaw clenching
	Toothaches/sensitive/bad fillings		Speech or swallowing difficulties		Jaw joint clicks or pops
	Treated for periodontal/gum problems		Gum boils, canker sores, cold sores		Pain or tingling in neck or head
	Wisdom tooth problems		Thumb or finger sucking habit		

How many times/day do you brush?_____ How many times/week do you floss?_____

Sports/Hobbies_____Mouthguard worn? ☐Yes ☐No

Wind instruments played regularly:_____

Have you had previous orthodontic treatment? ☐Yes ☐No; Describe:_____

Anything else you would like to tell us?_____

MEDICAL HISTORY

Physician's Name or Clinic_____ Phone #(_____)_____-_____

When was your last medical checkup? Mo_____ Year____,

Are you being treated for any chronic health conditions?_____

Any medical symptoms not currently under treatment?_____

Are you taking any medications, prescription, over the counter or herbal/dietary supplements? ☐Yes ☐ No

Medication_____ Taken for _____ How long_____

Medication_____ Taken for _____ How long_____

Hospitalizations/Surgical procedures:_____

Tobacco usage: ☐ Chew, ☐ Smoke, Pack years_____; Any substance abuse history? ☐Yes ☐No

Female Only: Are you pregnant? ☐Yes ☐No; Trimester 1 2 or 3

Children Only:

Growth prediction **female**: Age at first menstrual period ☐Not yet; ☐ Yes, age _____ ☐Recent rapid height growth

Growth prediction **male**: ☐Voice change; ☐Rapid height growth; ☐Adult hair patterns; ☐ More muscular

Growth prediction **family**: Birth father's Ht ____ft ____in. Birth mother's Ht ____ft ____in.

Check √ if now or in the past have you had diseases/treatment of:

	Birth / genetic defects		Neurologic disease, MS, fainting		**Cardiovascular/Breathing problems**
	Endocrine or thyroid		Mental health problems, depression		Heart murmur, rheumatic heart disease
	Kidney disease or Diabetes		Eating disorders, bulimia, anorexia		Congenital heart defects
	Osteoporosis **or meds to treat**		ADHD, ADD, Autism		Mitral valve prolapse /Valve replacement
	Cancer, radiation, chemotherapy		Growth problems		High or low blood pressure
	Stomach ulcer or acid reflux		Rheumatoid or arthritic conditions		Lung disease
	Immune system, HIV, AIDS		Bone fractures, any major accidents		Bleeding, bruising or anemia
	Hepatitis, jaundice, liver		Prosthetic joint replacement		Mouth breathing, snoring, sleep apnea
	Skin disease		Eye, ear, nose or throat/tonsillitis		Hay fever, asthma, sinusitis

Notes on medical history:_____

_____

Check √ ALLERGIES

	Local anesthetics novocaine, lidocaine		Codeine or other narcotics		Latex, exam gloves, balloons
	Aspirin, Motrin, Advil, Naprosyn, ibuprofen		Metals, jewelry, nickel		Vinyl, acrylic, plastics
	Penicillin /Sulfa or other antibiotics		Foods (specify)		Animals
	Other (specify)				

I have read and understand the above questions. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform the doctor.

Signed:_____ _____

Patient or Custodial Parent/Legal Guardian **Mark J. Bentele, DDS, MS**

Dated: _____/_____/20___ **Dated: :** _____/_____/20___