MARK PREVITT DMD ORTHODONTICS

MEDICAL/DENTAL HISTORY FOR ADULT

DATE___________________

NAME____AGE___ DOB______________ ___ SEX_____
ADDRESS____ HOME PHONE____________________
CELL PHONE___________________ EMAIL________________________________ SS#_______________
DENTIST___________________________ PHYSICIAN_______________________
ORAL SURGEON______________________ PERIODONTIST___________________
REFERRED BY____

EMPLOYER___________________________ OCCUPATION_____________________
BUSINESS ADDRESS____
BUSINESS PHONE NUMBER______________

DENTAL INSURANCE CO_____________________________ORTHODONTIC COVERAGE? Y N NOTSURE
NAMES OF FAMILY MEMBERS TREATED IN THIS PRACTICE__________________________________
CHIEF CONCERN OR COMPLAINT____
HAS ORTHODONTIST BEEN CONSULTED PREVIOUSLY? Y N

PLEASE CHECK ANY OF THE FOLLOWING WHICH PATIENT HAS OR HAD

__DIABETES
__PNEUMONIA
__HEART CONDITION
__RHEUMATIC FEVER
__BONE DISORDERS
__HEPATITIS OR LIVER PROBLEM
__EATING DISORDER
__HIGH/LOW BLOOD PRESSURE
__AUTISM
__TOOTH GRINDING OR CLENCHING
__TUBERCULOSIS OR MONONUCLEOSIS
__ANEMIA OR BLOOD DISORDER
__EPILEPSY OR SEIZURES
__ASTHMA
__KIDNEY DISEASE
__IMMUNE DISORDERS
__THYROID/ENDOCRINE CONDITION
__SPEECH PROBLEMS
__THUMB, FINGER OR PACIFIER HABIT
__JAW PAIN OR CLICKING
__FACIAL OR DENTAL TRAUMA
__FAINTING OR DIZZINESS
__AIDS OR HIV+
__BIRTH DEFECTS/HEREDITARY CONDITION
__CANCER OR TUMOR
__EAR, NOSE, THROAT OR EYE CONDITION
__MENTAL DISORDER/BEHAVIORAL CONDITION
__SUBSTANCE ABUSE OR ALCOHOLISM
__FREQUENT HEADACHES

PLEASE ELABORATE IF ANY CHECKED ABOVE____
CURRENT DRUGS OR MEDICATIONS____
ALLERGIES OR DRUG SENSITIVITIES____
ARE YOU PREGNANT OR ATTEMPTING TO BECOME PREGNANT? Y N
DO YOU SMOKE OR CHEW TOBACCO? Y N

SIGNATURE_______________________________