prairieridge
ORTHODONTICS
JEFF LOVELESS DDS MS

Name: _____

Nickname: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Phone: _____

B-Day: _____

Gender: _____

Activities:_____

_____

_____

_____

Responsible: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

_____

Whom may we thank for referral to our practice:_____

Employer:_____

Work Phone: ( )_____

Cell Phone: ( )_____

E Mail:_____

Dentist:_____

Last Visit Date:_____

Is your dentist recommending any dental work at this time? _____

MEDICAL AND DENTAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness or operations? _____

Yes No Have you ever been involved in a serious accident?_____

Circle any of the medical conditions below that you have had or currently have.

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

Yes No Do you or have you ever had TB? _____

Yes No Do you have a chronic cough? _____

Yes No Do you ever cough up blood? _____

Yes No Do you have night sweats? _____

Are there any other medical conditions you feel we should be aware of? _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have there been any injuries to face, mouth or teeth? _____

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Has anyone in your family received orthodontic treatment?

How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day?_____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have “tension” headaches? _____

Yes No Female Patients only: Are you pregnant? _____

I consent to the taking of photographs and X-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the Orthodontist to share this patient’s treatment information with collaborating dentist and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

Signature of patient or parent/guardian (if patient under 18) Date

Our office will not be responsible for any problems arising out of inadequate information not disclosed. Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDA and the ADA.

Signature of Orthodontist Date