

Darlene M. Byrd, D.D.S., M.S.D.

Orthodontics

PATIENT HISTORY FORM – ADULT

Name: _____

Age: _____ Sex: _____ Birthdate: _____

Address: _____

Home Phone: () _____

Social Sec. No.: _____

Employer: _____

Position: _____

Address: _____

Work Phone: () _____

Spouse/Partner: _____

Work Phone: () _____

Employer: _____

Position: _____

Who may we thank for referring you to our office? _____

What is your main concern about your teeth? _____

DENTAL HISTORY:

Dentist: _____

Phone: () _____

Address: _____

Last visit to dentist: _____

Periodontist: _____

Phone: () _____

Oral Surgeon: _____

Phone: () _____

Endodontist: _____

Phone: () _____

How many times a day do you brush your teeth? _____

Date of last X-ray: _____

Have you ever had:

Orthodontic treatment Yes _____ No _____

Clicking of the jaw Yes _____ No _____

Oral surgery Yes _____ No _____

Pain Yes _____ No _____

Periodontal treatment Yes _____ No _____

Difficulty opening and closing Yes _____ No _____

Your bite adjusted Yes _____ No _____

Difficulty chewing Yes _____ No _____

Worn a bite plate, nightguard Yes _____ No _____

Habits – Do You?

Bite your fingernails? _____ Yes _____ No _____

Clench or grind your teeth while awake or asleep? _____ Yes _____ No _____

Bite your lip or cheeks regularly? _____ Yes _____ No _____

Hold foreign objects with the teeth (such as pencils, pipe, pins, nails)? _____ Yes _____ No _____

Mouth breathe while awake or asleep? _____ Yes _____ No _____

Do you have headaches? _____

Frequency: _____

Location: _____

Has there ever been trauma or injury to the teeth or face? _____ Yes _____ No _____

MEDICAL HISTORY:

Physician: _____

Phone: () _____

Anemia Yes _____ No _____ Fainting Yes _____ No _____ Respiratory disorders Yes _____ No _____

Arthritis or joint disease Yes _____ No _____ Head & neck pain Yes _____ No _____ Rheumatic fever Yes _____ No _____

Asthma Yes _____ No _____ Heart disease Yes _____ No _____ Tuberculosis Yes _____ No _____

Bone disorders Yes _____ No _____ Kidney involvement Yes _____ No _____ Venereal disease Yes _____ No _____

Cancer Yes _____ No _____ Liver disease Yes _____ No _____ Herpes II, AIDS, Yes _____ No _____

Dizziness Yes _____ No _____ Nervousness Yes _____ No _____ Positive HIV status Yes _____ No _____

Epilepsy Yes _____ No _____ Prolonged bleeding Yes _____ No _____ Hypertension Yes _____ No _____

List all drugs or medication now being taken: _____

List allergies: _____

Any other medical considerations: _____

Women: Are you pregnant? _____

GUARANTOR: (Person financially responsible for the patient's account)

Name: _____ Relation to patient: _____ Home Phone: () _____

Address: _____ Work Phone: () _____

E-mail Address: _____

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history record, I will so inform the practice. I also authorize Dr. Darlene Byrd to perform an orthodontic examination.

Signature: _____ Date: _____
Responsible Party

Reviewed by: _____