



MEDICAL/DENTAL HISTORY

Patients Name _____

Physician's Name _____ 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? _____

YES NO Are you currently under a physician's care? _____

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

- | | | | |
|-------------------------|----------------|--------------------------|--------------------------|
| Abnormal bleeding | Diabetes | Hepatitis/Liver problems | Rheumatic Fever |
| Anemia | Dizziness | Herpes | Tuberculosis |
| Arthritis | Epilepsy | High Blood Pressure | Autism Spectrum Disorder |
| Asthma | Heart Murmur | HIV/AIDS | |
| Congenital Heart Defect | Heart Problems | Kidney problems | |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dentist's Name _____ Date of last cleaning _____

What concerns you most about your teeth? _____

Please circle yes or no

YES NO Have you ever seen an orthodontist? If yes, who and when? _____

YES NO Have your tonsils and adenoids been removed? _____

YES NO Are you allergic to latex? _____

YES NO Are you allergic to nickel? _____

YES NO Do you need antibiotics before seeing the dentist? _____

Please circle any of the dental conditions below that you have had or currently have.

- | | | | |
|-----------------------------|----------------------|---------------------|-------------------|
| Cold Sores | Jaw/Facial Injuries | Mouth Breathing | Tension Headaches |
| Clenching/Grinding of teeth | Jaw Clicking/Popping | Ringing in the ears | Thumb Sucking |
| Dental/Tooth Injuries | Jaw Locking | Smoke/Vape | Tongue Thrust |

Are there any dental conditions we have not discussed that you feel we should be aware of? _____

AFFIRMATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office immediately of any changes in medical status I hereby give Team Memphis Orthodontics permission to confirm appointments using the phone number(s) or emails I have provided, to include leaving messages. In addition, I authorize the orthodontist to perform a complete orthodontic evaluation.

Patient/Parent/Guardian Signature Date

Doctor Signature Date