MEDICAL 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 or latex? _____
Yes No Do you have a history of a major illness?_____
Yes No Have you had any major 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	Pneumonia	Herpes
Hepatitis/Liver problems	Anemia	Dizziness	Bone Disorders
Radiation/Chemotherapy	Arthritis	Epilepsy	High Blood Pressure
Asthma or Hayfever	HIV / Aids	Tumor or Cancer	Rheumatic Fever
Gastrointestinal Disorders	Kidney problems	Tuberculosis	Heart Murmur
Congenital Heart Defect	Nervous Disorders	Heart Problems	Prolonged Bleeding

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

DENTAL HISTORY

Dentist_____Date of last visit_____
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 you ever lost or chipped any teeth?_____
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 Would you object to wearing orthodontic appliances (braces) should they be indicated?
Yes No Has anyone in your family received orthodontic treatment? (Who)_____
How did they feel about the result?_____
What is your attitude toward receiving orthodontic treatment?_____
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 Have you ever experienced chronic ringing in your ears?_____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours?_____

Female Patients only:
Yes No Are you pregnant?
Yes No Has menstration started?

**By signing, I agree that the information is true to the best of my knowledge. I have received the Privacy Policies of Neale Orthodontics. I hearby authorize OrthoBanc, LLC, on behalf of Dr. William D. Neale to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. I consent to the taking of photographs and x-rays before, after and during treatment and to the use of same by the doctor in scientific papers or demonstrations.*

*Signature of Parent / Guardian:*_____