

WRIGHT ORTHODONTICS

Dental and Medical History for _____

Have you ever been evaluated for orthodontic treatment? _____

Doctor's name _____ Date of treatment _____

Have you ever been told you have, or been treated for periodontal (gum) problems? _____

If so, explain _____

Do you have any of the following habits:

Grinding Teeth _____

Clenching Teeth _____

Mouth Breathing _____

Nail Biting _____

Are you currently under the care of a physician? _____

Are you taking any prescription drugs? _____

If so, please list each one and the purpose. _____

Are you allergic to any of the following?

Penicillin _____

Erythromycin _____

Tetracycline _____

Other Allergies _____

Latex _____

Dental Anesthetics _____

Codeine _____

Have you ever had any of the following medical problems:

Heart attack/stroke _____

Rheumatic fever _____

HIV/Aids _____

Kidney problems _____

Sinus problems _____

Fever blisters _____

Severe/frequent headaches _____

Other Medical Problems _____

Diabetes _____

Hemophilia/bleeding _____

Epilepsy/fainting _____

Hepatitis _____

Drug/alcohol abuse _____

Anemia _____

Asthma _____

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature

Date