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detterlineorthodontics

PLEASE NOTE: You should complete and print form to bring with you to your appointment. Or you may save to your computer and email as an attachment to info@detterlineorthodontics.com

New Market Office
11717 Old National Pike
p 301.831.3900
f 301.831.3195

Patient Information:

Patient's Name ____ Date ____

Address ____

Home Phone ____ Birth Date ____ Age ____ Sex ____

School ____ Grade ____

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

General Dentist ____

Siblings: Name ____ Age ____ Name ____ Age ____

Responsible Party/ Insurance Information:

Parent's Name(s) (or self) ____

Address ____

How long at this address ____ Home Phone ____ Work ____

Previous Address (if less than 3 years)

____

SS Number ____ Birth Date ____ Relationship to Patient ____

Employer ____ Occupation ____ Yrs. Employed ____

Insured's Name ____

Insurance Company ____ Insured's SS Number ____

Group number ____ Member ID ____

Do you have dual coverage? ☐ Yes ☐ No If Yes please provide information for 2nd policy:

____

Emergency Information:

Name of nearest relative not living with you:

____ Phone ____

Complete Address ____

This office reserves the right to verify the credit status of potential patients seeking payment terms.

Signature ____ **Date** ____

Dental History

Name of Dentist | Date of last visit to this dentist

Dental Specialists who have treated you (Give Names, Treatments & Dates):

How many times per day do you ***BRUSH*** your teeth: 0 ☐ 1 ☐ 2 ☐ 3+ ☐ How many times per day do you ***FLOSS*** your teeth? 0 ☐ 1 ☐ 2 ☐

History of:	Specifics of Problems if *YES*:	Please Explain any *YES* answers
Tooth Injury?	NO ☐ **YES** ☐ Chipped ☐ Broken ☐ Lost ☐	
Oral Disease?	NO ☐ **YES** ☐ Ulcers ☐ Sores ☐	
Jaw Joint Pain?	NO ☐ **YES** ☐ **Right T.M.J.** ☐ Constant ☐ Periodic ☐ When you: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐ NO ☐ **YES** ☐ **Left T.M.J.** ☐ Constant ☐ Periodic ☐ When you: Chew ☐ Yawn ☐ Talk ☐ Open Wide ☐	
Jaw Joint noises?	NO ☐ **YES** ☐ **Right T.M.J.** Clicking ☐ Popping ☐ Grating ☐ At Age: NO ☐ **YES** ☐ **Left T.M.J.** Clicking ☐ Popping ☐ Grating ☐ At Age:	
Jaw Joint Locking?	NO ☐ **YES** ☐ **Right T.M.J.** ☐ When Open ☐ When Closed ☐ Dates Of Locking: NO ☐ **YES** ☐ **Left T.M.J.** ☐ When Open ☐ When Closed ☐ Dates Of Locking:	
Grinding Your teeth?	NO ☐ **YES** ☐ During the day ☐ When Sleeping ☐	**Comments:**
Clenching Your teeth?	NO ☐ **YES** ☐ During the day ☐ When Sleeping ☐	**Comments:**
Bleeding Gums?	NO ☐ **YES** ☐ Usually ☐ Sometimes ☐ Rarely ☐ Presently under a Dentist's care for it? NO ☐ **YES** ☐ When? Brushing ☐ Flossing ☐ Eating ☐	
Oral Habits?	NO ☐ **YES** ☐ Thumb Sucking ☐ Finger Sucking ☐ Tongue Thrusting ☐ Nail Biting ☐	**Comments:**
Other Oral Problems?	NO ☐ **YES** ☐ If YES, please explain	

Speech Problems: NO ☐ **YES** ☐

Have you ever had:

Teeth Extracted?	NO ☐	**YES** ☐	Which Teeth?
Periodontal (gums) treatment?	NO ☐	**YES** ☐	What Kind of Treatment?
Orthodontic (braces) treatment?	NO ☐	**YES** ☐	What Kind of Treatment?
Endodontic (root canal) treatment?	NO ☐	**YES** ☐	What Kind of Treatment?
Oral Surgery (jaw surgery) treatment?	NO ☐	**YES** ☐	What Kind of Treatment?
Prosthodontic (crown & bridge) treatment?	NO ☐	**YES** ☐	What Kind of Treatment?

Please state in your own words why you are interested in orthodontic treatment:

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time. I will keep the doctor and staff of this practice informed of any changes in this information as it occurs

Signature of person filling out this health history

Date this history was completed

Signature of T.C. who reviewed this history

Signature that the examining DOCTOR reviewed this history

Date of Interview & DOCTOR review of this history

Date above T.C. reviewed this history

Medical History

Name of Physician ______ Date of last visit to this physician ______

Are there anySpecialists you see regularly? ______

Date of your last complete physical exam: ______ Examining doctor's name: ______

Your approximateheight: ___ ft. ___ in. Your approximate weight ______ Your body frame size: Small Medium Large

History of:		Specifics of Problems if YES
Head/Neck Problems?	NO ☐ YES ☐	Headaches: Migraine ☐ Sinus ☐ Eyes ☐ Temple ☐ Back of head ☐ Painful Scalp ☐ Neck Pain ☐ Lumps in neck ☐ Tired/Sore neck muscles ☐
Neurological Problems?	NO ☐ YES ☐	Epilepsy ☐ Seizures ☐ Numbness/tingling ☐ Other ☐ ______
Eye Problems?	NO ☐ YES ☐	Pain ☐ Bloodshot ☐ Blurred Vision ☐ Pressure on eyeballs ☐ Light Sensitivity ☐ Watery ☐ Drooping Eyelids ☐ Other ☐
Ear Problems?	NO ☐ YES ☐	Pain ☐ Clogged ☐ Hissing ☐ Ringing ☐ Dizziness ☐ Nausea ☐ Loss of Hearing Volume ☐ Loss of Balance ☐
Nose/Sinus Problems?	NO ☐ YES ☐	Obstruction ☐ Stuffiness ☐ Runny Nose ☐ Other ☐ ______
Throat Problems?	NO ☐ YES ☐	Sore Throat ☐ Swallowing Difficuly ☐ Lump in Throat ☐ Laryngitis ☐ Voice Fluctuations ☐ Tongue Pain ☐ Persistent Coughing/Clearing Throat ☐
Breathing Problems?	NO ☐ YES ☐	Asthma ☐ Wheezing ☐ Shortness of Breath ☐ Chronic Cough ☐ Cough up Blood/Sputum ☐
Back Shoulder Extremity Problems?	NO ☐ YES ☐	Aching Shoulders or Stiffness ☐ Lack of Mobility ☐ Upper ☐ Lower ☐ Back Pain ☐ Numbness in Arms ☐ Cramps in Legs: When Walking ☐ At Night ☐ Arms/Legs Weakness ☐ Leg/Ankle Swelling ☐ Gout ☐
Bone Problems?	NO ☐ YES ☐	Break Easily ☐ Pain ☐ Arthritis ☐ Joint Pain ☐ Joint Swelling ☐
Breast Problems?	NO ☐ YES ☐	Pain ☐ Lumps ☐ Disease ☐ Other ☐ ______
Heart Problems?	NO ☐ YES ☐	Coronary Heart Disease ☐ Heart Valve Disease ☐ High Blood Pressure ☐ Chest Pain ☐ Angina ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Palpitations ☐
Urinary System Problems?	NO ☐ YES ☐	Urgency ☐ Painful Urination ☐ Frequent Urination ☐ Nighttime Urination ☐ Release when sneeze/Cough ☐ Blood in Urine ☐ Kidney Infection ☐
Stomach & Intestine Problems?	NO ☐ YES ☐	Ulcers ☐ Bleeding ☐ Abdominal Pain ☐ Heartburn ☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Gall Bladder Disease ☐ Intestinal Disease ☐ Black Stool ☐ Intolerance to: Milk ☐ Eggs ☐
Endocrine Problems?	NO ☐ YES ☐	Pancreas ☐ Thyroid ☐ Pituitary ☐ HIV+ ☐ Other ☐ ______

______ Dr's Initials ______

______ TC's Initials ______

PLEASE COMPLETE AND REVIEW ALL 4 SECTIONS BEFORE PRINTING OR SUBMITTING

History of: | **Specifics of Problems if YES** | **Please Explain and list any medications & dosage)**

Liver Problems? NO ☐ YES ☐

Kidney Problems? NO ☐ YES ☐

Blood Problems? NO ☐ YES ☐ — Hemophilia ☐ Anemia ☐ Bruise Easily ☐ HIV+ ☐ Bleed Easily ☐ Blood Clots ☐ Had Stroke ☐

Chronic Disease Problems? NO ☐ YES ☐ — Diabetes ☐ Cancer ☐ Hepatitis A ☐ B ☐ Tuberculosis ☐ Infectious Diseases ☐ Swelling ☐ Tonsillitis ☐ Excessive Colds ☐

Skin Problems? NO ☐ YES ☐ — Eczema ☐ Dry ☐ Oily ☐ Itchy ☐

One time Problems? NO ☐ YES ☐ — Mumps ☐ Age Fiel ☐ Rheumatic Fever ☐ Age Fiel ☐ Measles ☐ Age Fiel ☐ ChickenPox ☐ Age Fiel ☐

Heart Surgery? NO ☐ YES ☐ — Heart Valve ☐ Pacemaker ☐ Bypass ☐ Other ☐

Other Surgery? NO ☐ YES ☐ — Tonsils ☐ Adenoids ☐

Serious Injury? NO ☐ YES ☐ — Broken Bones ☐ Other ☐

Occupational Disease? NO ☐ YES ☐

Has the Patient Reached Puberty? Female started menstruation? NO ☐ YES ☐ Male had voice change? NO ☐ YES ☐

Has a physician indicated that the patient is Maturing:

NORMALLY? NO ☐ **YES** ☐ LATER than normal? NO ☐ **YES** ☐ EARLIER than normal? NO ☐ **YES** ☐

Which parent does the patient resemble? Mother ☐ Father ☐ Neither ☐ Both ☐

Exercise Regularly? NO ☐ **YES** ☐ ☐ Hours/Day Week ☐ Month ☐

Psychological Problems? NO ☐ **YES** ☐ Depression ☐ PsychiatricDisorder ☐ Anxiety ☐ Insomnia ☐

Presently taking Medication? NO ☐ **YES** ☐ Birth Control ☐ Diuretics ☐ Blood Pressure ☐ Blood thinners ☐ Heart ☐ Tranquilizers ☐

Allergic Reactions? NO ☐ **YES** ☐ Hay Fever ☐ Foods ☐ Metals/Plastics ☐

Drug Reactions? NO ☐ **YES** ☐ Anti-bacterialDrugs ☐

Anesthetic Reaction? NO ☐ **YES** ☐ Local Anesthetic ☐ General Anesthetic ☐

FOR ADULTS ONLY:

Habit Excesses? NO ☐ **YES** ☐ Smoking ☐ Packs/Day ☐ for ☐ years. Caffeine ☐ Alcohol ☐ Overeating ☐

Has your hat size increased recently? NO ☐ **YES** ☐ When?

Are you in sunlight daily? NO ☐ **YES** ☐ How long?

Do you take calcium or vitamin D? NO ☐ **YES** ☐ How much?

Have you decreased in height? NO ☐ **YES** ☐ If yes, how much and when did it occur?

Have you noticed a more stooped posture? NO ☐ **YES** ☐ If yes, when?

Do you eat and drink dairy products? NO ☐ **YES** ☐ If yes, how many servings per day?

Do you drink alcoholic beverages? NO ☐ **YES** ☐ If yes, how many drinks per day?

WOMEN:

Are your menstrual periods regular? NO ☐ **YES** ☐ If not, do you know why not?

Have you entered menopause? NO ☐ **YES** ☐ If so, how many years ago?

If you have children, list your age at their births: NO ☐ **YES** ☐

Dr's Initials _______

TC's Initials _______