**ADULT MEDICAL/DENTAL HISTORY**

What are some main concerns that you would like orthodontics to accomplish?

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Have you ever been evaluated or had orthodontic treatment before?

[] Yes [] No

Have you seen an orthodontist? If so who and when?

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Do you have any family members in treatment with Turner Orthodontics? If yes, who?

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Have there been any injuries to the face, mouth, teeth, or chin?

[] Yes [] No

Have adenoids or tonsils been removed?

[] Yes [] No

Do you snore?

[] Yes [] No

Have you ever been informed of any missing or extra permanent teeth?

[] Yes [] No

Have you ever had any pain/tenderness in jaw joint? (TMJ/TMD)

[] Yes [] No

Do you brush your teeth daily?

[] Yes [] No

Do you floss your teeth daily?

[] Yes [] No

Are you currently under the care of a physician?

[] Yes [] No

Primary Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any family history of under or overbites?

[] Yes [] No

Please describe your current physical health:

[] Good [] Fair [] Poor

Please list all medications that you are currently taking:

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Please list all drugs that you are allergic to:

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What is your reaction to orthodontic treatment?

[] Excited [] Nervous [] Complacent [] Dreading

Are you aware that some appointments will infringe upon times during the work day?

[] Yes [] No



Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**Signature**

Have you ever had any of the following medical problems?

Bone Disorder Y. N.

Allergic to Latex/Metals Y. N.

Congenital Heart Defect Y. N.

Convulsions/ Epilepsy Y. N.

Abnormal Bleeding Y. N.

Hearing Impairment Y. N.

Kidney/Liver Problems Y. N.

Handicap/ Disabilities Y. N.

Allergies to any Drugs Y. N.

Cleft Lip or Palate Y. N.

Nutritional Problems Y. N.

Fainting or Dizziness Y. N.

Any Dental Pain Y. N.

Emotional Problems Y. N.

Autism Y. N.

Special Needs Y. N.

Need to Medicate Before Clinical Procedure Y. N.

Please discuss any medical or dental problems that you have or had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced any unfavorable reaction to dentistry, resulting in dental phobia? If so explain in further detail.

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Do you have any of the following?

Thumb sucking Y. N.

Lip Sucking/biting Y. N.

Clenching/ Grinding Teeth Y. N.

Mouth Breather Y. N.

Speech Problems Y. N.

Nail Biting Y. N.

Tongue Thrust Y. N.

Any other questions or concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I also authorize the orthodontic staff to perform the necessary dental services that I may need.

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