F. Brent May DMD, MSD, Pc

Specialist In Orthodontics

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Medical Dental History Form

Date:__________________

Patients Name:____**Date of Birth:**_______________________Age:_______Sex_______
Patients Address:_______________________________________City:_______________________________State:__________Zip:___________
Home Phone #:________________________****Cell Phone #:**____________________________****Cell Phone Company:**_______________
****Email Address:**____

Employer:____Occupation:______________________Work #:______________________
****Social Security Number:**__________________________

Spouse:______________________________ Home #:________________________Cell #:_______________________Cell Phone Company:______________
Address:____ City:____________________________________ State:__________Zip:____________
Occupation:____________________________________Employer:____________________________________ Work #:______________________
****Social Security Number**:__________________________ ****Date of Birth**: ______________________________

Patient is: Single____ Married____ Widowed____ Separated____ Divorced____

Names and ages of children in family:____ **Family Members in Treatment**:________________

Dental History

Name of Patients Dentist:________________________________ Phone #:__________________Referred By:_____________________________

Last Dental Visit:______________________Dental Work Being Done Now: Y___ N___ If Yes, What:___________________________________
Has the Patient had Orthodontic Treatment or Evaluation?___________If Yes, By Whom:____
What do you feel are the Orthodontic Problems: ☐ Alignment of Teeth ☐ Dental Protrusion ☐ Facial Features ☐ Other
Please explain:____
Who First Noticed the Need for Orthodontic Treatment?____
Additional Comments:____

Y__ N__ Jaw fractures, cysts, mouth odor

Y__ N__ Bleeding gums, bad taste in mouth

Y__N__ Periodontal "gum problems"

Y__N__ Thumb or finger sucking habit

Y__N__ Mouth breathing habit, snoring, Difficulty in breathing

Y__N__ Teeth grinding, jaw clenching, clicking, locking

Y__N__ Do you experience any pain or soreness in the muscle of your face or around the ears?

Y__N__ Have you ever been treated for "TMJ" problems? (Jaw joint and facial muscle pain)

Y__N__ Have you had any serious trouble associated with any previous dental treatment?

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Medical History

Health Quality: □ Good □ Fair □ Poor

Allergies: □ None □ Food □ Drug □ Hay Fever □ Asthma □ Other

Specific Type of Food/Drug Allergy:________________________________

Has the patient had any of the following: **(Please Circle)**

Hepatitis	Diabetes	Kidney Problems	Sinus Problems	Immune Disorder	Lip or Tongue Biting
Frequent Headaches	Heart Disease	Bleeding Gums	Arthritic Conditions	Speech Impairment	Nail Biting
Cerebral Palsy	Epilepsy	Liver Disease	Convulsions/Seizures	Tonsils/Adenoids	Tuberculosis
Rheumatic Fever	Excessive Bleeding	Cold Sores/Fever Blisters	Throat Infections	Mouth Breathing	Hemophilia
Frequent Colds	Thyroid Problems	Dizziness or Fainting	Grinding of Teeth	Thumb/Finger Sucking	Difficult Breathing
Latex Sensitivity	Artificial Joints	AIDS/HIV	Radiation Therapy	Chemotherapy	Cancer/Tumors
Anemia	Vision Impairment	Hearing Impairment	Cardiovascular Problems	Mental Health/Behavioral Problems	
High Blood Pressure	Low Blood Pressure	Other			

Please Explain Above:____

If female, are you currently pregnant: Yes____ No____

Physician Name:________________________Phone #:__________________

List Drugs Regularly Taken & Reason:____

____

Orthodontic Insurance

Primary

Orthodontic Coverage: Yes____ No____
Group # (plan or policy #):______________________
Insurance Co. Phone #:________________________
Subscriber's name:__________________________
Subscriber's Date of Birth: ______________________

Insurance Co. Name: ________________________________
Subscriber's I.D. #:________________________________
Insurance Co. Address:______________________________
Insured's Employer:________________________________

Person Financially Responsible for Account: ______________________________________
Phone Number:______________________****Cell Phone Number**_______________****Cell Phone Company** ______________
Address:____**City/State/Zip**:__________________________
****Financially Responsible Party's Email Address**____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment?____

____

I certify that I have answered the above questions to the best of my ability. I will not hold Dr. F Brent May or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

______________________________________ ______________________

Signature of Patient (or Guardian) **Date**

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