dr.gaik orthodontics children & adults

DATE:_____

NAME:_____

ADDRESS:_____CITY:_____POSTAL CODE:_____

BIRTHDATE: Month _____ Day _____ Year _____

Home Phone Number: _____ Cell Phone Number: _____
(These numbers are important for confirming your appointments and in the case of an emergency. Please keep updated)

E-mail contact _____

Mother's name:_____ Father's name:_____

Legal Guardians (if different): _____

Dentist:_____Doctor:_____

MEDICAL HISTORY
List all allergies (medications / latex / metals / foods):_____

List all medications being taken: _____

Y N Has there been trauma to the head, neck or jaw? Please explain_____
Y N Is the patient's jaw painful? Does it click? Is there limited movement? _____
Y N Does the patient smoke? How much?_____
Y N Is the patient pregnant? Due date: _____
Y N Have the patient's tonsils and adenoids been removed? When_____

Y N Is the patient in good health?

CIRCLE IF THE PATIENT HAS HAD ANY OF THE FOLLOWING:

Arthritis / Anemia / Asthma / Angina
Bleeding Disorder / Birth Defect (Please elaborate _____)
Chest Pain / Cancer / Chemotherapy (Please elaborate _____)
Dizziness / Diabetes / Digestive Disorders / Drug Dependence (Please elaborate_____)
Epilepsy (Seizures) / Eating Disorders
Headaches / Hearing disorder / High blood pressure / Heart problems _____
Heart murmur (Do you require prophylactic antibiotics for dental work? _____
Hepatitis A / Hepatitis B / Hepatitis C / Liver Disease _____
HIV / AIDS
Jaundice / Artificial Joint Replacement _____
Lung Disease / Shortness of Breath
Nasal/Sinus Problems / Nervous disorders _____
Rheumatic Fever / Scarlet Fever / Staph or Strep Infections / Stroke
Tonsillitis / Tuberculosis (status _____) / Thyroid Disease _____
Visual Disorders
THE ABOVE MEDICAL HISTORY IS CORRECT AND COMPLETE :Please sign _____

EMERGENCY CONTACT PERSON _____ Contact # _____

Y N Do we have permission to release information to your dentist?
Y N Do you have any orthodontic insurance coverage?