ARCADIA ORTHODONTICS
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(626)294-9119
(626)294-9241 fax

Welcome to our office. Please take a few minutes and complete this medical history so that we can serve you better.

Patient Information

Last Name:____________________ First Name:____________________ M.I.____
Address:____________________ City____________________
State:__________ Zip Code:__________ Birthday __________
Social Security Number____________________ Home Phone#__________
Sex: M / F e-mail____________________ Cell Phone#__________

Financial Responsible Party

Last Name:____________________ First Name:____________________ M.I.____
Address:____________________ City:____________________
State:__________ Zip Code:__________ Telephone#__________
Social Security Number____________________ Birthday__________
Employed by____________________ Drivers License#__________
Employer Address____________________ City:____________________
State:__________ Zip Code:__________ Work Phone#__________

Who may we thank for referring you to our office?____________________
Dentist Name____________________ Phone #____________________
Physician's Name____________________ Phone#____________________

Do you have orthodontic insurance? _______Yes _______ No

Insurance Company____________________ Phone #____________________
Policy Holders Social Security Number____________________ Group#__________
Policy Holders Name____________________ Birthday__________

DENTAL HISTORY

Have there been any injuries to your face, mouth or teeth?____________________Yes No
Has the patient ever sucked a thumb or fingers? Until what age?____________________Yes No
Does patient have any speech problems?____________________ Yes No
Is patient a mouth breather? ____________________Yes No
If Yes, please check one _______Daytime ________Sleep ____________All the time
Last visit to family dentist:______________ Was Cleaning done? ____Yes ___No
Does patient have any jaw pain, clicking or discomfort in the TMJ (jaw joints)_____Yes No
If patient had braces before, please indicate approximate duration of treatment______________
Year completed:_____________
If this is a transfer case, Name of Doctor:__________________When started_______________
Date of last visit____________________

MEDICAL HISTORY

Is the patient in good health?__________ Yes No
Is the patient currently under a physicians care?__________ Yes No
If Yes, please explain:__________
Is the patient taking any medication?__________ Yes No
Is the patient allergic to any medication?__________ Yes No
Is the patient allergic to latex?__________ Yes No
Has the patient ever taken Fen-Phen?__________ Yes No
Has the patient ever been hospitalized?__________ Yes No
Has the patient ever had surgery?__________ Yes No
Has the patient ever taken Bisphosphonate: -- Yes No

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE YES OR NO)

Anemia	yes	no	Head injuries	yes	no	Blood transfusion	yes	no
Herpes	yes	no	Hear failure	yes	no	Nervous disorder	yes	no
Strokes	yes	no	Liver disease	yes	no	Psychiatric treatment	yes	no
Ulcers	yes	no	Scarlet fever	yes	no	Tumors	yes	no
Diabetes	yes	no	Chicken pox	yes	no	Allergies or hives	yes	no
Glaucoma	yes	no	Sinus Trouble	yes	no	Asthma	yes	no
Allergies	yes	no	Arthritis	yes	no	Prolonged bleeding	yes	no
Cold sores	yes	no	Blood disease	yes	no	Congenital heart disease	yes	no
Epilepsy	yes	no	Heart murmur	yes	no	Bruise easily	yes	no
Seizures	yes	no	Heart attack	yes	no	Difficulty swallowing	yes	no
Hepatitis	yes	no	A.I.D.S.	yes	no	H.I.V. positive	yes	no
Cancer	yes	no	Thyroid disease	yes	no	Cerebral Palsy	yes	no
Tumors	yes	no	Convulsions	yes	no	Hearing problem	yes	no

Other__________

If you have answered yes to any of the above questions, or feel that there is anything else we should be aware of please explain:__________

____

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What is your primary reason for seeking orthodontic treatment?__________

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The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in the patient's medical status.

Signature of patient or legal representative__________ Date__________

Signature of Dentist__________ Date__________