Member
American Association of Orthodontists

RONALD C. PERKINS, DDS MSD PC
ORTHODONTIC ACQUAINTANCE

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PATIENT HISTORY

Date ______________________ Date of Birth ______________________

Patient's Name ______________________ Age __________ Sex __________
Last First Initial

Res. Address ______________________ Phone ______________________

City ______________________ State __________ Zip __________

Occupation ______________________ Soc. Sec. No. ______________________

Employed by ______________________ Business Tel. __________ Cell __________

O.K. to contact at work? Yes ☐ No ☐ E-Mail Address ______________________

Bus. Address ______________________ City __________ Zip __________

Do you have orthodontic insurance? Yes ☐ No ☐ Group # __________ Group Name __________

Name of Spouse ______________________ Soc. Sec. No. ______________________

Employed by ______________________ Occupation ______________________

Bus. Address ______________________ City __________ Zip __________ Tel. __________

Does your spouse have orthodontic insurance? Yes ☐ No ☐ Group # __________ Group Name __________

Responsible Party ______________________ Dental Insurance ______________________

Name of Physician ______________________ Name of Dentist ______________________

Referred by ______________________ Ages of children at home ______________________

Do you anticipate a move or transfer in the near future? Yes ☐ No ☐

MEDICAL HISTORY

1. Are you in good health? ______________________ Yes ☐ No ☐
2. At present, are you under medical care? ______________________ Yes ☐ No ☐
3. What was the purpose of the visit to your physician? ______________________
4. Have you ever had a severe illness? ______________________ Yes ☐ No ☐
5. Check those items which you now are or have been treated for:

a. Anemia	Yes ☐	No ☐	
b. Arthritis or joint disease	Yes ☐	No ☐	
c. Asthma	Yes ☐	No ☐	
d. Adenoids/Tonsils problems	Yes ☐	No ☐	
e. Allergies	Yes ☐	No ☐	
f. Bone disorders	Yes ☐	No ☐	
g. Cancer	Yes ☐	No ☐	
h. Dizziness	Yes ☐	No ☐	
i. Ear problems	Yes ☐	No ☐	
j. Epilepsy	Yes ☐	No ☐	
k. Fainting	Yes ☐	No ☐	
l. Head and neck pain	Yes ☐	No ☐	
m. Heart disease	Yes ☐	No ☐	
n. Kidney involvement	Yes ☐	No ☐	
o. Liver disease (hepatitis)	Yes ☐	No ☐	
p. Nervousness	Yes ☐	No ☐	
q. Prolonged bleeding	Yes ☐	No ☐	
r. Respiratory disorders	Yes ☐	No ☐	
s. Rheumatic fever	Yes ☐	No ☐	
t. Tuberculosis	Yes ☐	No ☐	
u. Venereal disease	Yes ☐	No ☐	
v. Herpes II, Aids, etc.	Yes ☐	No ☐	
w. Prosthetic Implants	Yes ☐	No ☐	

Endocrine Problems

1. Thyroid Yes ☐ No ☐
2. Diabetes Yes ☐ No ☐
3. Other ______________________

Drug Sensitivities

1. Novocain Yes ☐ No ☐
2. Penicillin Yes ☐ No ☐
3. Aspirin Yes ☐ No ☐
4. Codeine Yes ☐ No ☐
5. Other ______________________

6. Do you have any diseases we should be aware of? ______________________ Yes ☐ No ☐
7. List all drugs or medication now being taken: ______________________
8. Has anyone in your family had diabetes? ______________________ Yes ☐ No ☐
9. Women: Are you pregnant? ______________________ Yes ☐ No ☐

continued on back

Dental History

Are you missing any permanent teeth? ______ Yes ☐ No ☐

Have you ever had:

a. Orthodontic treatment? ______ Yes ☐ No ☐

b. Oral Surgery? ______ Yes ☐ No ☐

c. Periodontal treatment? ______ Yes ☐ No ☐

d. Your teeth ground or the bite adjusted? ______ Yes ☐ No ☐

e. Worn a bite plate or other appliance? ______ Yes ☐ No ☐

Problems of the jaw - Have you ever experienced:

a. Clicking/Popping of the jaw? ______ Yes ☐ No ☐

b. Pain (joint, ear, side of face)? ______ Yes ☐ No ☐

c. Difficulty in opening and closing? ______ Yes ☐ No ☐

d. Headaches (frequency & location)? ______ Yes ☐ No ☐

e. Jaw locked? ______ Yes ☐ No ☐

Habits - Do you:

a. Bite your fingernails? ______ Yes ☐ No ☐

b. Clench or grind your teeth while awake or asleep? ______ Yes ☐ No ☐

c. Bite your lips or checks regularly? ______ Yes ☐ No ☐

d. Hold foreign objects with the teeth (pencils, pipe)? ______ Yes ☐ No ☐

e. Mouth breathe while awake ? ______ Yes ☐ No ☐

When did you first become aware of your orthodontic problem? ______

______

How did you first hear about our office? ______

Who first made you aware of a need for orthodontic evaluation? ______

Reason for today's visit ______

I authorize Dr. Ronald C. Perkins to use Nitrous Oxide if necessary to aid in discomfort. Yes ☐ No ☐

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history record, I will so inform this practice. I also authorize Dr. Ronald C. Perkins to perform an orthodontic examination.

______ Signature ______ Date

This information has been reviewed with the above named individual.

______ Signature ______ Position ______ Date