



MEDICAL HISTORY UPDATE FOR ORTHODONTIST

All questions contained in this questionnaire are strictly confidential and will become part of the patient's record. A medical history update must be provided once per year.

Patients Name: _____ Date of Birth: _____
Patient's Primary Address: _____
Parent or Guardian's Email Address: _____ Mobile: _____
Who does the patient live with? Both Parents Mother Father Other _____
Who brought in the parent today? Mother Father Other _____
Primary Insurance: _____ Subscriber Name: _____ DOB: _____
Member Id # or SS# of the Subscriber _____

Orthodontic Consultation Questions

Dentist: _____ Date of last visit: _____
What concerns you most about your teeth? _____

- YES / NO Are you presently in any dental pain? _____
- YES / NO Have you ever experienced any unfavorable reaction to dentistry? _____
- YES / NO Have you ever lost or chipped any teeth? _____
- YES / NO Have there been any injuries to face, mouth, or teeth? _____
- YES / NO Is any part of your mouth sensitive to temperature or pressure? _____
- YES / NO Do your gums bleed when you brush? _____
- YES / NO Do you have any type of thumb or tongue habit? _____
- YES / NO Are you a mouth breather? _____
- YES / NO Have you ever seen an orthodontist? If yes, who and when? _____
- YES / NO Would you object to wearing orthodontic appliance (braces) should they be indicated? _____
- YES / NO Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
What is your attitude toward receiving orthodontic treatment? _____
- YES / NO Do your teeth or jaw ever feel uncomfortable when you awake in the morning? _____
- YES / NO Are you aware of your jaw clicking or popping? _____
- YES / NO Are you aware of clenching your teeth during the day? _____
- YES / NO Have you ever been told that your grind your teeth? _____
- YES / NO Do you have "tension" headaches? _____

YES / NO If the patient is under age 16, height of parents? **Mom** _____ **Dad** _____

YES / NO Are you aware that some appointments will be during school/work hours? _____

Please list some hobbies or interests _____

Female Patients only:

YES / NO Are you pregnant? _____

YES / NO Has menstruation started? _____

Benefits of Orthodontics

Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of the teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Elana Yerushalmi Norman, DDS, MS, PC to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Dr. Norman Signature of review: _____