JOHNSTON ORTHODONTICS, LLC
PATIENT INFORMATION AND MEDICAL HISTORY

Please fill out both sides of form completely.

Name:_______________________________ Nickname: _________________ Date:__________
First MI Last

Date of Birth:____________ Age:________ ☐ Male ☐ Female

Address:____
Mailing Address **(No PO Boxes)** City State Zip

Home Phone: ______________ Work Phone: _____________ Marital Status:_______________

E-Mail Address:____

Name of School:_______________________ Grade:_________________

Employer:_________________ Occupation:_______________ Social Security:_____________
(if the patient is an adult)

Spouse or Parent's Name:____

Physician:________________________________ Dentist:____________________________

Whom may we thank for referring you:____

Previous Orthodontic Experience:____

Name and Ages of brothers & sisters:____

***please complete the following**:* ❖❖

Has the patient ever had:

☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Lung Disease
☐ Arthritis	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Fainting Spells	☐ H.I.V.	☐ Thyroid Problem
☐ Bleeding Problems	☐ Hearing Problems	☐ Kidney Disease	☐ Tuberculosis
☐ Cold Sores	☐ Heart Condition	☐ Liver Disease	

Comments:____

Does the patient have allergies to: ☐ Seasonal Grasses ☐ Drug/Medication ☐ Foods ☐ Other
Comments:____

Has the patient been under the care of a physician during the past two years, other than for routine examinations or colds? ☐ Yes ☐ No

Condition:____

Does the patient require premedication for dental procedures? ☐ Yes ☐ No

Is the patient presently on medication? ☐ Yes ☐ No

If yes, please list:____

Does the patient have any birth defects? ☐ Yes ☐ No

Is the patient pregnant? ☐ Yes ☐ No

Has the patient started her menstrual cycle? If yes, at what age?_______ ☐ Yes ☐ No

Have the patient's tonsils been removed? ☐ Yes ☐ No

Has the patient ever experienced TMJ pain or noise? ☐ Yes ☐ No

Is the patient a mouth breather? ☐ Yes ☐ No

Has the patient had speech therapy? ☐ Yes ☐ No

Has the patient had a thumb or finger sucking habit? ☐ Yes ☐ No

Please turn page over