# Dorothy E. Whalen, D.D.S., P.C.

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS
PRACTICE LIMITED TO ORTHODONTICS

Name _____ Sex _____ Age _____ Birthdate _____

Home Address _____ Phone _____

Cell _____ Email _____

Future Billing address if different from above _____

Occupation _____ Employer _____

Spouse's Name _____ Occupation _____

Dentist _____ Address _____

Physician _____ Address _____

Who referred you to us? _____

Chief Orthodontic concern? _____

## MEDICAL HISTORY

Name of physician _____

Date of last visit: _____

1. Are you currently under the care of a physician? If so, for what reason or condition?

_____

2. Are you currently taking any medication? If so, what medication and for what reason or condition?

_____

3. Do you have a heart condition that requires you to take antibiotic premedication?

_____

4. Have you ever had or been treated for any of the following? Please answer yes or no. If yes, please explain below.

- Allergies or hay fever _____
- Hepatitis, jaundice, liver disease _____
- HIV or AIDS _____
- Breathing problems _____
- Tuberculosis _____
- Injury to your head or neck _____

5. Do you smoke? _____

Are there any other problems about your health of which you are aware? Please explain.

_____

_____

_____

_____

(Please complete reverse side)>>

# DENTAL HISTORY

Name and address of dentist _____

_____

Date of last visit: _____

1. Have you had any previous orthodontic treatment?

_____

2. Do you grind your teeth or clench your jaws?

_____

3. Do you have pain or clicking in your jaw joints?

_____

4. Can you breathe through your nose easily?

_____

5. Is there a history of finger or thumb sucking?

_____

6. Have you ever seen a speech therapist?

_____

7. Have you had your tonsils or adenoids removed? ___

8. Are you a good toothbrusher? _____

9. Are there any other problems about your dental health of which you are aware? Please explain.

_____

_____

_____

_____

This information you have provided may be shared with your dentist if it relates to your orthodontic therapy. Be sure to inform us if there is any change in your medical or dental history. Please discuss with us anything you feel is important to your orthodontic treatment.

_____ _____

Person completing this form (print name) Signature of person completing form

Date _____