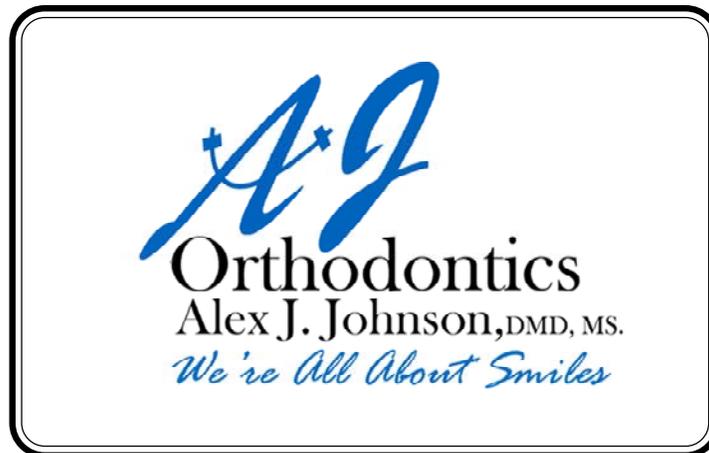


Welcome to the Orthodontic Practice of:

Alex J. Johnson, D.M.D., M.S.

3840 Tampa Road
Palm Harbor, FL 34684



Thank you for choosing our office for your orthodontic consultation. We look forward to speaking with you and addressing your orthodontic concerns. Our goal is to provide you with the best possible care and treatment. Please carefully complete the enclosed medical and dental information so that we may be of better service to you. Thanks!

PATIENT INFORMATION

Patient's Name _____ M _____ F _____ Today's Date _____
Address _____ Date of Birth _____ Age _____
City _____ Zip _____ School _____ Grade _____
Patient's Physician _____ Patient's Dentist _____
Nickname _____ Phone: Home _____ Work _____
Names and ages of other children in family _____ SS# _____
Names of other family members in our orthodontic practice _____

RESPONSIBLE PARTY Adult Patients: Please complete this form for yourself and your spouse.
Parents: If completing this form for a minor (less than 18 years of age), please complete parental information.

(Circle One)

Father / Husband / Self	Name _____	Address (if different) _____
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Occupation _____ City _____ Zip _____
Employed By _____ Social Security # _____
Business Address _____ Phone: Home _____ Work _____
Drivers license # _____ Relationship to patient _____
Email Address _____

(Circle One)

Mother / Wife / Self	Name _____	Address (if different) _____
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Occupation _____ City _____ Zip _____
Employed By _____ Social Security # _____
Business Address _____ Phone: Home _____ Work _____
Drivers license # _____ Relationship to patient _____
Email Address _____

MEDICAL HISTORY

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is the patient <u>presently</u> under the care of a physician for a major illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Does the patient have any history of a major illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Is the patient in good health? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has the patient had their tonsils (<u>circle</u>) or adenoids (<u>circle</u>) removed? What age? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | If not removed, does the patient have regular problems with their tonsils or adenoids? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Female patients: Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. If a child: Has the patient reached puberty? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Is the patient currently taking any medications? Please list: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Does the patient have any physical or emotional limitations? |
| | | 9. Has the patient ever had (or have) any problems with any of the following? |

- | YES | NO | | YES | NO | | YES | NO | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Nervous disorders | <input type="checkbox"/> | <input type="checkbox"/> | Bone Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Valves | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip/Palate |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Hearing | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Has the patient been advised to take antibiotics prior to dental visits? | | | | | | |
| | | If so, by what doctor? (name and phone number) _____ | | | | | | |

10. Does the patient have or has the patient been exposed to any of the following?
YES NO YES NO

- Hepatitis HIV Positive/AIDS
 Tuberculosis Venereal Diseases

11. Does the patient have allergies to any drugs? Please list: _____

12. Does the patient have any other allergies? Please list: _____

13. Has the patient been told that they have an underbite?

14. Is there a known family history of any family member with an underbite?
If yes, what is the relationship to the patient? _____

Patient with Underbite



Please note: Refer back to questions 1,2,8,9,10,11 & 12. If they are answered YES, please explain below. Also, describe any other medical problems not yet covered.

No further problems to note

YES NO

DENTAL HISTORY

14. Has there been any injuries to the face, mouth, teeth or jaw joints? When? _____

15. Does the patient have speech problems? Any previous therapy? _____

16. Has the patient ever sucked the thumb or fingers? Until what age? _____

17. Does the patient snore while sleeping?

18. Does the patient breathe through the mouth rather than the nose? Sometimes Usually

19. Has the patient ever been informed of any missing permanent teeth?

20. Has an orthodontist been previously consulted? When? _____

21. Has the patient ever had orthodontic treatment? When? _____

What treatment was rendered? _____

22. Has either parent had orthodontic treatment? Which? _____

23. Does the patient have pain in the jaw joint?

24. Does the patient have clicking in the jaw joint? How often? _____

25. Does the patient clench and/or grind the teeth?

26. Has the patient ever been diagnosed as having jaw joint (TMJ) problems? When? _____

27. Does the patient bite their fingernails?

28. Does the patient place objects (pens, pencils, etc.) in the mouth?

29. Does the patient play a contact sport? Which? _____

30. Does the patient play a musical instrument? Which? _____

31. Has the patient been seen by their dentist recently? When? _____

What was done? _____ When are they scheduled to return? _____

How often does the patient see their dentist? _____

32. Why are you seeking this consultation?

To correct overbite

To close spaces

To straighten teeth

To improve facial proportions

To correct the crossbite

Other (*be specific*) _____

To eliminate facial pain

To help clicking jaw

To correct jaw problem

To improve general appearance

To correct an underbite

Please cover any problems or concerns not yet covered and expand on any previous questions as needed.

We always appreciate the referral of patients to our office and like to thank those who have made the referral. Whom may we thank for referring you to our office? _____

Thank you for choosing our office for your orthodontic consultation. Most orthodontic appointments are scheduled during school or work hours. We respect your need to be treated promptly and for this reason, we are proud of the fact that we receive our patients at their appointed time. We are able to provide this high level of service when our patients arrive on time for their appointments. Therefore, we ask that everyone arrive on time for all scheduled appointments. Please remember that if you must reschedule your appointment, kindly give us twenty-four hours advance notice.

We make a sincere effort to schedule convenient appointment times for our patients. However, it is necessary to alternate morning and afternoon appointments, particularly during the school term.

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent.

Date _____

Signature _____

Relationship to patient _____

Legal guardian (*if different*) _____

FOR STAFF USE ONLY

Health Alerts:

Health history reviewed by: _____ Initial _____ Date _____ Dr. Initial _____

Before: Yes No

Notes: _____

HEALTH HISTORY - Significant findings

Concern _____

Checked with _____

Physician _____ Checked by _____

Date _____

Physician RX: _____