FLYNN
ORTHODONTICS

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Medical/Dental History
Adult

Date:

Patient's Name: Sex: Age: Birthdate:

Preferred Name: Referred by:

Address City Zip Phone:

Family email address:

Place of employment: Occupation:

Phone (home): (work): (cell):

Spouse's Name: Occuption:

Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐Widowed

Child's Name: DOB: Child's Name: DOB:

Child's Name: DOB: Child's Name: DOB:

Person responsible for Account: ☐ Self ☐ Spouse ☐ Other Name:

Address: City: Zip: Phone:

DENTAL INSURANCE

Primary Insurance Co: Group:

Insured's Name: S.S.#: Birthdate:

Secondary Insurance Co: Group:

Insured's Name: S.S.#: Birthdate:

PERSONAL MEDICAL AND DENTAL REPORT

Your careful and complete answers to these questions will do much to enable us to make the most helpful orthodontic recommendations. Please be sure to provide additional information wherever applicable.

This report is being completed by: ☐ Self ☐ Other:

Name: Date

Physician City

How long has he/she been your physician? Date of last visit

Dentist City

How long has he/she been your dentist? Date of last visit

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
❒	❒	AIDS	❒	❒	Hair or skin disorder	❒	❒	Premedication required
❒	❒	Arthritis	❒	❒	Heart problems	❒	❒	Seizures
❒	❒	Asthma	❒	❒	Headaches	❒	❒	Sinus trouble
❒	❒	Artificial joint	❒	❒	Hepatitis_____	❒	❒	Frequent sore throats
❒	❒	Blood disorders	❒	❒	Herpes	❒	❒	Special diets
❒	❒	Diabetes	❒	❒	HIV positive	❒	❒	Tuberculosis
❒	❒	Digestive disorders	❒	❒	Jaw clicking/pain	❒	❒	Under physicians care
❒	❒	Endocrine problems	❒	❒	Kidney /liver disorder	❒	❒	Use tobacco
❒	❒	Eye problems	❒	❒	Mouth breathing	❒	❒	Adenoids removed
❒	❒	Gagging, nausea	❒	❒	Rheumatic fever	❒	❒	Tonsils removed
			❒	❒	Under physicians care	❒	❒	Joint or TMJ problems

❒ ❒ Surgeries_____

❒ ❒ Emotional/psychiatric problems_____

❒ ❒ Taking medication_____

Serious childhood diseases_____

How is your health now?_____

Height_____ Weight_____ Recent changes_____

Any other medical conditions not mentioned?_____

DENTAL HISTORY

Yes	No		Yes	No	
❒	❒	Six month dental cleanings	❒	❒	Relaxed during dental visits?
❒	❒	Are teeth sensitive?	❒	❒	Grind your teeth?
❒	❒	Do gums bleed easily?	❒	❒	Chew nails?
❒	❒	Do you enjoy eating?	❒	❒	Able to chew food well?
❒	❒	Facial muscle twitches or hab	❒	❒	Injury to any teeth?_____

Number of times per day teeth are brushed_____

Did you ever suck your: ☐thumb ☐ fingers ☐tongue ☐ foreign object ☐ until age: ☐ still do

Chief orthodontic complaint_____

Do you have any unusual dental problems other than the orthodontic problem_____

When did you first become aware of this orthodontic problem?_____

Is there any similarity to: ☐ father ☐ mother ☐ others in the family ☐ none? ☐ In what way?_____

Has there been any previous orthodontic treatment or consultation? ☐ yes ☐ no Where?

I have completed the health questionnaire and certify that the preceding information is true and Correct. The office will not be held responsible for any problems arising out of inadequate information not disclosed. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I understand that, where appropriate, Credit Bureau reports may be obtained.

Signature of parent or Guardian:_____

Date:_____

Please use this space for any additional comments, questions, or requests which you would like to make.

Thank you for your cooperation! Denise R. Flynn, D.D.S., M.S.