MyFamily
Orthodontics

Established Patient- Dental/Medical History Update **Date:** _____

Patient Name: _____ DOB: _____

Contact Information:

Email: _____ Ph# _____

Any address change? Yes: _____ No: _____

New Address: _____

Any changes with dental insurance? Yes: _____ No: _____

If yes New Ins: _____

Primary Care Physician

Doctors Name: _____ Ph # _____

Dentist

Doctors Name: _____ Ph # _____

Has the patient had any change with their dental health since your last visit with us?
Yes: _____ No: _____ If yes please explain?

_____

Has the patient had any change with their health since your last visit us? Yes: _____ No: ____
If yes please explain?

_____

Has the patient had any surgeries or hospitalizations since your last visit with us?
Yes: _____ No: _____

If Yes; Date of surgery/hospitalization and details:

_____

Has the patient had any recent diagnosis of cancer or any other issue? Yes: _____ No: _____
if yes please explain?

_____

_____

Has the patient had any recent diagnosis of Autism, ADHD, or any other neurological/ development disorder?
Yes: _____ No: _____ If so, please explain?

_____

_____

Is the patient currently taking any medications or supplements (prescription and/or non-prescription)? Yes: _____ No: _____ If yes please list medications:

_____

Is the patient allergic to any medications, foods, or latex? Yes: _____ No: _____ if yes please explain?

_____

Is the patient currently using any tobacco products? Yes: _____ No: _____ if yes please explain?

_____

FEMALES ONLY: Is the patient currently taking birth control? Yes: _____ No: _____

FEMALES ONLY: Is the patient pregnant? Yes: _____ No: _____

I Certify that have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires above have been answered to my satisfaction. I will not hold Dr. Johnson, or any other member of her staff, responsible for any errors or omissions that I have made in my completions of this form.

_____
Parent/Patient (Print Name)

_____ **Date:** _____
Parent/Patient (Signature)