

DENTAL HISTORY

Dentist _____ Date of Last Dental Exam _____

Circle (Yes / No) if you have had problems with any of the following:

Bad Breath	Yes / No	Bleeding gums	Yes / No	Clicking, popping, locking of jaw	Yes / No
Sensitivity to cold	Yes / No	Sensitivity to hot	Yes / No	Food collecting between teeth	Yes / No
Sensitivity to sweets	Yes / No	Periodontal treatment	Yes / No	Grinding/clenching teeth	Yes / No
Sores in mouth	Yes / No	Loose/Broken teeth	Yes / No	Thumb/finger sucking	Yes / No
Mouth breathing	Yes / No	Snoring	Yes / No	Nail biting	Yes / No

Any injuries to mouth Yes / No If yes please explain _____

Have you ever been evaluated for orthodontic treatment? Yes / No Orthodontist _____

MEDICAL HISTORY

Physician's Name _____ Phone # _____

Any recent illness(or)surgeries Yes / No If yes describe _____

Are you currently under physician care Yes / No If yes, describe _____

Do you still have: Tonsils Yes / No Adenoids Yes / No

For Women: Are you pregnant? Yes / No Taking birth control pills Yes / No

Circle (Y: Yes or N: No) whether you have (or) had any of the following:

AIDS/HIV+	Y / N	Hepatitis	Y / N	High Blood pressure	Y / N	Stroke	Y / N
Anaphylaxis	Y / N	Diabetes	Y / N	Epilepsy	Y / N	Asthma	Y / N
Fainting	Y / N	Hemophillia	Y / N	Cancer	Y / N	Heart attack	Y / N
Sinus Prob.	Y / N	Heart Murmur	Y / N	Congenital Heart Def.	Y / N	Jaw Pain	Y / N
Headaches	Y / N	Kidney Disease	Y / N	Liver Disease	Y / N	Tuberculosis	Y / N
Cold Sores	Y / N	Drug/Alcohol abuse	Y / N	Mitral Valve Prolapse	Y / N	Rheum Fever	Y / N

Are you taking any medication for your bones? Yes / No If yes, List _____

Are you currently taking any medications? Yes / No If Yes, List _____

Do you have any drug allergies? If Yes, List all: _____

Allergic to LATEX YES / NO

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the orthodontic staff to perform the necessary orthodontic services I may need.

I authorize Central Park Orthodontics, on behalf of Dr. George Pliakas, to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

I have also read, understand and have been offered a copy of the HIPPA consent form.

Signature

Date