

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: _____ Occupation: _____

Marital 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

- | | | |
|---|--|--|
| <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> |
| <input type="checkbox"/> <input type="checkbox"/> AIDS | <input type="checkbox"/> <input type="checkbox"/> Hair or skin disorder | <input type="checkbox"/> <input type="checkbox"/> Premedication required |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Heart problems | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> <input type="checkbox"/> Artificial joint | <input type="checkbox"/> <input type="checkbox"/> Hepatitis_____ | <input type="checkbox"/> <input type="checkbox"/> Frequent sore throats |
| <input type="checkbox"/> <input type="checkbox"/> Blood disorders | <input type="checkbox"/> <input type="checkbox"/> Herpes | <input type="checkbox"/> <input type="checkbox"/> Special diets |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> HIV positive | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> <input type="checkbox"/> Jaw clicking/pain | <input type="checkbox"/> <input type="checkbox"/> Under physicians care |
| <input type="checkbox"/> <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> <input type="checkbox"/> Kidney /liver disorder | <input type="checkbox"/> <input type="checkbox"/> Use tobacco |
| <input type="checkbox"/> <input type="checkbox"/> Eye problems | <input type="checkbox"/> <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> <input type="checkbox"/> Gagging, nausea | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> <input type="checkbox"/> Surgeries_____ | <input type="checkbox"/> <input type="checkbox"/> Under physicians care | <input type="checkbox"/> <input type="checkbox"/> Joint or TMJ problems |
| <input type="checkbox"/> <input type="checkbox"/> Emotional/psychiatric problems_____ | | |
| <input type="checkbox"/> <input type="checkbox"/> Taking medication_____ | | |

Serious childhood diseases _____

How is your health now? _____

Height _____ Weight _____ Recent changes _____

Any other medical conditions not mentioned? _____

DENTAL HISTORY

- | | |
|---|---|
| <u>Yes</u> <u>No</u> | <u>Yes</u> <u>No</u> |
| <input type="checkbox"/> <input type="checkbox"/> Six month dental cleanings | <input type="checkbox"/> <input type="checkbox"/> Relaxed during dental visits? |
| <input type="checkbox"/> <input type="checkbox"/> Are teeth sensitive? | <input type="checkbox"/> <input type="checkbox"/> Grind your teeth? |
| <input type="checkbox"/> <input type="checkbox"/> Do gums bleed easily? | <input type="checkbox"/> <input type="checkbox"/> Chew nails? |
| <input type="checkbox"/> <input type="checkbox"/> Do you enjoy eating? | <input type="checkbox"/> <input type="checkbox"/> Able to chew food well? |
| <input type="checkbox"/> <input type="checkbox"/> Facial muscle twitches or hab | <input type="checkbox"/> <input type="checkbox"/> 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.

