DR. MICHAEL A. JACK, D.D.S., M.S.

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MEDICAL AND DENTAL INFORMATION
PRELIMINARY INFORMATION

Today's Date _____

Patient's Name _____ (Last / First / Middle) Nickname _____ Sex M F

Date of Birth _____ / _____ / _____ (mo. / day / yr.) Age, in Years _____ School _____ Grade _____

Home Address _____ (Street No. / Street Name) Phone _____

City _____ State _____ Zip Code _____

Email _____

Father's Name _____ (Last / First / Middle) Social Security No. _____ Date of Birth _____

Father's Occupation/Employer _____ Business Phone No. _____

Business Address _____ (Street No. / Street Name / City / State / Zip)

Mother's Name _____ (Last / First / Middle) Social Security No. _____ Date of Birth _____

Mother's Occupation/Employer _____ Business Phone No. _____

Business Address _____ (Street No. / Street Name / City / State / Zip)

Person Responsible for Account if Now Divorced or Separated _____

DENTAL INSURANCE INFORMATION

Subscriber Name _____ ID. # _____

Insurance Co. _____ Group # _____

Insurance Co. Address _____ Insurance Co. Phone # _____

MEDICAL HISTORY

The patient's Medical and Dental History information is very Important. This Information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Is patient in good health? ..... Yes No

2. Has there been any change in patient's general health within the past year? ..... Yes No

3. Is patient now under the care of a physician? ..... Yes No
If so, what is the condition being treated? _____

4. The name and address of patient's physician(s) is _____
_____
_____

5. Is patient taking any medicine(s) including non-prescription medicine? ..... Yes No
If so, what medicine(s) are being taken? _____

6. Has patient had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
If so, what was the illness or problem? _____

7. Have Tonsils and Adenoids been removed? If yes, when? _____ Yes No

8. Has patient had any Injuries to the face, head or teeth?
If yes, please give complete details including date(s) of occurrence, nature of injury and who treated: Yes No
_____
_____
_____

9. Does patient have or has had any of the following diseases or problems?

- **a.** Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? ..... Yes No
- **b.** Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No
  - **1.** Pain in chest upon exertion? ..... Yes No
  - **2.** Ever short of breath after mild exercise or when lying down? ..... Yes No
  - **3.** Do ankles swell? ..... Yes No
  - **4.** Have inborn heart defects? ..... Yes No
  - **5.** Have a cardiac pacemaker? ..... Yes No
  - **6.** Ever had heart surgery? ..... Yes No
- **c.** Allergy ..... Yes No
- **d.** Sinus trouble ..... Yes No
- **e.** Asthma or hay fever ..... Yes No
- **f.** Fainting spells or seizures, dizziness ..... Yes No

g. Persistent diarrhea or recent weight loss ..... Yes No
h. Diabetes ..... Yes No
i. Hepatitis, jaundice or liver disease ..... Yes No
j. AIDS or HIV infection . ..... Yes No
k. Thyroid problems ..... Yes No
l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
m. Arthritis or painful swollen joints ..... Yes No
n. Stomach ulcer or hyperacidity ..... Yes No
o. Kidney trouble. ..... Yes No
p. Tuberculosis ..... Yes No
q. Persistent cough or cough that produces blood. ..... Yes No
r. Persistent swollen glands in neck ..... Yes No
s. Low blood pressure ..... Yes No
t. Sexually transmitted disease .. .. Yes No
u. Epilepsy or other neurological disease ..... Yes No
v. Problems with mental health ..... Yes No
w. Cancer ..... Yes No
x. Problems of the immune system ..... Yes No
y. Alcoholism or drug dependency or addiction ..... Yes No
aa. Scarlet Fever ..... Yes No
bb. Chemotherapy ..... Yes No
cc. Radiation Therapy. ..... Yes No
dd. Cortisone Therapy ..... Yes No
ee. Cosmetic Surgery .. .. Yes No
ff. Diabetes ..... Yes No
gg. Rheumatism ..... Yes No
hh. Epilepsy ... . Yes No
ii. Chicken Pox ..... Yes No
jj. Fever Blisters ..... Yes No
kk. Glaucoma ..... Yes No
ll. Measles ..... Yes No
mm. Mumps ..... Yes No
nn. Nervousness/anxiety ..... Yes No
oo. Psychological treatment ..... Yes No
pp. Psychiatric Treatment ..... Yes No
qq. Ulcers ..... Yes No

10. Has patient had abnormal bleeding? ..... Yes No
a. Has patient ever required a blood transfusion ..... Yes No
11. Does patient have any blood disorder such as anemia, hemophelia, leukemia, sickle cell disease? .. .. Yes No
a. Does patient bruise easily ..... Yes No
12. Has patient ever had any treatment for a tumor or growth? ..... Yes No
13. Is patient allergic or had a reaction to:
a. Local anesthetics ..... Yes No
b. Penicillin or other antibiotics ..... Yes No
c. Sulfa drugs ..... Yes No
d. Barbiturates, sedatives, or sleeping pills ..... Yes No
e. Aspirin ..... Yes No
f. Iodine.. ..... Yes No
g. Codeine or other narcotics. ..... Yes No
h. Other _____

14. Has patient had any problems associated with any previous dental treatment? ..... Yes No
If so, explain _____
_____

15. Does patient have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
If so, explain _____
_____

16. Is patient wearing contact lenses? ..... Yes No
17. Is patient wearing removable dental appliances? ..... Yes No

Women

18. Is patient pregnant? ..... Yes No
19. Is patient nursing? .... Yes No
20. Is patient taking birth control pills? ..... Yes No
21. Is there any other medical (health) information you would like us to know? If yes, please explain _____ Yes No

The medical information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in my health and of recent visits to my physician at my next visit. In addition, I authorize Dr. Jack to perform a complete orthodontic examination.

Date _____ Signature _____

DENTAL HISTORY
GENERAL DENTAL INFORMATION

1. When was patient's last dental visit? _____
2. How frequently does patient visit his or her dentist? _____
3. The name and address of patient's dentist is: _____
4. When was patient's last full mouth or panoramic series of x-rays? _____
5. Is patient having any dental problems now? ..... Yes No
   If yes, please specify _____
   _____
6. I would describe patient's temperament as: _____
7. Patient's hobbies or sports interests are: _____
8. Do you anticipate a move or transfer in the near future? ..... Yes No
   If yes, please explain _____
9. Has Patient reached puberty? ..... Yes No
10. Is patient's teeth discolored? ..... Yes No
11. Has patient ever been in an auto accident? ..... Yes No
    If yes, please explain _____
    _____
12. Has patient ever had an injury to your head, face, or neck? ..... Yes No
    If yes, please explain _____
13. Has patient ever had teeth removed? ..... Yes No
14. Has patient's wisdom teeth been removed? ..... Yes No
    If yes, when and by whom? _____
15. What is patient's main reason for seeking orthodontic treatment? _____
    _____
16. Please specify any other reasons patients has for seeking orthodontic treatment? _____
    _____
    _____

ORTHODONTIC INFORMATION

1. Has patient ever had orthodontic treatment (braces)? ..... Yes No
   If yes, when and by whom _____
2. Has patient ever had an orthodontic examination, evaluation, conference or consultation? ..... Yes No
   If yes, when and by whom _____
3. Has patient ever had orthodontic records, such as x-rays, study models or photographs? ..... Yes No
   If yes, when and by whom _____

PERIODONTAL (GUM) INFORMATION

1. Do you feel patient's gingiva (gums) are healthy? ..... Yes No
   If no, please explain _____
2. Do patient's gums bleed when brushing? ..... Yes No
3. Has patient's gums ever bled when brushing? ..... Yes No
4. Does patient regularly use dental floss or tape? ..... Yes No
   If yes, since when? _____
5. Have you or patient ever been told that you have gum disease? ..... Yes No
   If yes, when and by whom? _____
6. Has patient ever been advised to have periodontal (gum) treatment? ..... Yes No
7. Has patient ever had a periodontal examination? ..... Yes No
   If yes, when and by whom? _____
8. Has patient ever had periodontal (gum) treatment? ..... Yes No
   If yes, when and by whom _____

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

1. Do you feel patient's jaw joint is healthy? ..... Yes No

If no, please explain _____

2. Does patient's jaw joints(s) click, crack, pop, grate or make any other sound(s)? ..... Yes No

If yes, please explain _____

3. Does patient grind teeth? ..... Yes No

4. Does patient clench teeth? ..... Yes No

5. Does patient ever have or has patient ever had jaw soreness, jaw pain, muscle soreness (jaw area) neck soreness? ..... Yes No

If yes, please explain _____

6. Does patient now or has patient previously experienced aches or pains in the following areas:

a. From of the head ..... Yes No
b. Over the eyes ..... Yes No
c. Sinus area ..... Yes No
d. Temple area ..... Yes No
e. Cheeks or side of the face ..... Yes No
f. Top of the head ..... Yes No
g. Back of the head ..... Yes No
h. Back of the neck ..... Yes No
i. Side of the neck ..... Yes No
j. Tongue or under the tongue ..... Yes No
k. Front of the neck ..... Yes No
l. Shoulders ..... Yes No
m. Upper back ..... Yes No
n. Lower back ..... Yes No
o. Other pain, please describe ..... Yes No

For the above problems, what circumstances seem to cause the problem(s). make it worse or make it better?

a) _____
b) _____
c) _____

7. Has patient's jaw ever "locked" open or closed? ..... Yes No

If yes, please explain _____

8. Has patient ever been told that you have a TMJ or "Jaw Joint" problem? ..... Yes No

If yes, when and by whom _____

9. Has patient ever had treatment for a TMJ "Jaw Joint" Problem? ..... Yes No

If yes, when and by whom _____

The dental information provided is complete and correct to the best of my knowledge.
I agree to inform this office of any change(s) in my dental health and of recent visits to my dentist at my next visit.

Date _____ Signature _____