

The Hills Orthodontics

5753 E. Santa Ana Canyon Rd., #K
 Anaheim, CA 92807
 714-998-4700 | thehillsortho25@gmail.com

Patient Information (confidential)

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment right now?.....	<input type="checkbox"/>	<input type="checkbox"/>	5. Are you allergic to or have you had any reactions to the following?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (eg. Novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medication?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medications are you taking? _____			Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
			Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been prescribed antibiotics prior to dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>		
4a. Have you ever taken phen-phen?.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			Other.....		
				
			6. Women only:		
			a) Are you pregnant or think you may be?.....		
			b) Are you nursing?.....		
			c) Are you taking birth control pills?.....		

7. Do you have or have had any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Coumadin Therapy.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....			Fainting / Seizures.....			Down Syndrome.....		
Prolonged Bleeding.....			Epilepsy / Convulsions.....				
Anemia.....			Diabetes.....			Alzheimer's.....		
.....				
Stroke.....			Kidney Disease.....			Aids or HIV Infection.....		
.....			Thyroid Problem.....			Sexually Transmitted Disease.....		
Joint Replacement or Implant.....						Other.....		

Patient Dental History

Yes No

Yes No

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|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while you are brushing or flossing?..... | <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you hard to get numb?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids / foods?..... | <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you apprehensive of dental treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had any prolonged bleeding following extraction?..... | <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you interested in sleep anesthesia?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you like the appearance of your teeth, your smile?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever experienced any of the following problems to your jaw?..... | <input type="checkbox"/> | <input type="checkbox"/> | a) If not, explain_____ | | |
| a) Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| b) Clicking or popping?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| c) Pain (joint, ear, side of face)?..... | <input type="checkbox"/> | <input type="checkbox"/> | 10. When was your last exam & cleaning done? _____ | | |
| d) Difficulty in chewing?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| e) Do you have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that no other dentist nor The Hills Orthodontics is responsible for my dental treatment. I hereby give my consent to have necessary treatment recommendations performed.

Signature of patient or parent (if minor)

Doctor's Comments _____	Signature _____	Date _____
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