Shah Orthodontics
Tarak V. Shah, D.D.S.

Dental and Health History

Name: ____ Date of birth: ____________________________

Medical History	Yes	No	Additional Information
Is the patient's general health good?			
Is the patient under medical treatment now? (Please specify as additional information)			
Has the patient been hospitalized for any surgical operations or illness in the past five years? (Please specify as additional information)			
Is the patient taking medication(s) including non-prescription medicine? (Please list as additional information)			
Is the patient allergic to any of the following (Please specify): __Medications __Latex __Any metals __Jewelry __Acrylics __Plastic ___Other			
Does the patient use tobacco: ___Cigarettes/Cigars ___Vaping ___Chew			
Is the patient pregnant or think they may be?			
Has the patient ever had an injury to the face, mouth, chin, or teeth? (Please specify as additional information)			
Does the patient have any delayed development, social disabilities, sensitivities, or behavioral conditions we should take into consideration during evaluation and/or treatment in order to provide a positive experience here in our office? (Please specify as additional information)			

Has the patient ever had any of the following conditions:

___ADD/ADH
___AIDS/HIV+
___Allergies/seasonal
___Allergies/food
___Arthritis
___Asthma
___Back/shoulder pain
___Bleeding/blood disorders
___Cancer
___Cold sores/oral ulcers
___Diabetes
___Endocrine/hormone disorders
___Epilepsy/seizures
___Eye pain
___Facial pain
___Gag reflex
___Headaches/migraines
___Hearing/ear disorders
___Heart condition/murmur
___Hepatitis/liver disease
___High/low blood pressure
___Jaw disorders/locking/TMD
___Kidney disorders
___Lung/respiratory disorders
___Mental health disorders
___Mitral valve prolapse
___Neck pain
___Osteoporosis/Osteopenia
___Prosthetics
___Tuberculosis (TB)

Are you aware of any medical conditions or diseases not listed? (Please specify)

Dental History	Yes	No	Additional Information
Does the patient require antibiotic premedication for dental procedures?			
Is the patient anxious or nervous about dental treatment?			
Approximately when was the patient's last cleaning?			
Does the patient have any of the following restorative dentistry? __Bridges __Implants __Crowns __Dentures			
Has the patient's dentist recommended any other dental procedures/treatment? (Please specify as additional information)			
Has the patient had periodontal (gum) treatment?			
Has the patient had a previous orthodontic evaluation?			
Has the patient had previous orthodontic treatment? Treating dentist: What type of treatment (i.e. braces, Invisalign): When:			

Does the patient have a history of any of the following:

___Clenching/grinding teeth
___Chipped/injured teeth
___Difficulty chewing/opening
___Difficulty breathing
___Missing teeth (congenital or extracted)
___Mouth breathing/snoring
___Periodontal (gum) problems/disease
___Speech problems
___Supernumerary (extra) teeth
___Thumb/finger habits (previous or current)
___Tongue thrust
___Other: ________________________________

Authorization

To the best of my knowledge, the above questions have been accurately answered. I understand it is my responsibility to inform Shah Orthodontics of any changes in the medical/dental status provided. I give Shah Orthodontics permission to perform an orthodontic examination and evaluation for the above noted patient.

____ Date: ______________________________
Patient/Parent or Guardian Signature