PATIENT HISTORY FORM – Dr. Renton Tindall – Orthodontist

PATIENT INFORMATION

Mr/Mrs/Ms. Name…….…….....

I.D. Number: …….....……..……...

Address: ……

……

Residential Tel:.……...Mobile No: ……..

Work Tel: ……. Fax: ……

E-mail Address:…….

Marital status:……

Dentist: ……..

Name and address of Medical Doctor: ……..……

…..…….…….

Who referred you to this practice: ……

Occupation: …….....

Medical Aid: …….

Medical Aid Number: ……..

Employer: ……..

Name and Address of Party Responsible for Account:

……...…….

……

…… Post Code: ……

DENTAL HISTORY
(Please tick)

		Yes	No
Have there been any injuries to the face, mouth or teeth? **(If so, please underline which one)**		……..	……..
Have you ever sucked a thumb or fingers? **(If so, until what age? …….)**		……..	……..
Do you have any speech problems?		……..	……..
Are you a mouth-breather?	While awake?	……..	……..
	While asleep?	……..	……..
Were any teeth removed at any time by a dentist? **(If so, which teeth ……. Age ……..)**		……..	……..
Do you grind teeth or bite your lip? (If so, please underline which one)		……..	……..
Have you been informed of any missing or extra permanent teeth? **(If so, please underline which one)**		……..	……..
Has an orthodontist been consulted previously?		……..	……..
Did mother or father have an orthodontic problem? **(Treated ……. Untreated ……)**		……..	……..
Do you have regular dental treatment?		……..	……..

N.B. – Is there anything that concerns you about your teeth? …….

……

Other relevant information ……

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MEDICAL HISTORY

(Please tick)

Present Health	Excellent	Good	Fair	Poor
Appetite	Excellent	Good	Fair	Poor

Have you ever been under the care of a physician during the past two years? **(if so, state condition and duration)**

…….. Yes/No

Check any of the following for which you may have been treated. State age and if severe

	Yes	No		Yes	No
Diabetes	……..	……..	Tuberculosis	……..	……..
Endocrine Problems	……..	……..	Pneumonia	……..	……..
Anaemia	……..	……..	Prolonged Bleeding	……..	……..
Heart Trouble	……..	……..	Epilepsy	……..	……..
Fainting or Dizziness	……..	……..	Rheumatic Fever	……..	……..
Asthma	……..	……..	Nervous Disorders	……..	……..
Bone Disorders	……..	……..	Kidney Involvement	……..	……..
Liver Involvement	……..	……..	HIV/Aids	…….	…….

Do you have tendency to colds, sore throat or ear infections? **(Underline which)**

Have Tonsils or Adenoids been removed? (If so, at what age ……)

List any other serious illnesses not mentioned above ……...

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List any medications now being taken. Give reasons ……

……

List any allergies or drug sensitivity: …….

……

List Family Members that are currently in our practice: ……..

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SIGNATURE: ……..