Michelle Dumiller Carlton, DDS
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Denham Springs, LA 70726
225-664-9699
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Date _____

PATIENT INFORMATION

Name (last) _____ **(first)** _____ **(middle)** _____

Name wishes to be called _____ **Birth date** ____/____/____ **Age** _____ **Sex M F**

Address _____ **City**_____ **St** _____ **Zip** _____

Phone: Home _____ **Work** _____ **Cell** _____

Employer _____ **Position** _____ **How Long?** _____

Email _____ **SS #** _____

Marital Status _____ **Spouse's Name** _____

Please list children and ages_____

General Dentist _____ **Family Physician** _____

Whom may we thank for telling you about our office? _____

APPOINTMENT CONFIRMATION

Would you like us to electronically confirm appointments by email and/or text message?

Yes: ____Email ____Text message Cell Company (ex: AT&T, Alltel...) _____

No: I would not like electronic reminders. Please call one of the following: ____Home ____Work ____Cell

ORTHODONTIC INSURANCE INFORMATION

Primary insurance company _____

Address _____ **Phone** _____

Policy / Group # _____ **Employer** _____

Insured's Name _____ **SS#** _____ **Birthdate** ____/____/____

Secondary insurance company _____

Address _____ **Phone** _____

Policy / Group # _____ **Employer** _____

Insured's Name _____ **SS#** _____ **Birthdate** ____/____/____

EMERGENCY INFORMATION

Who should we contact in case of an emergency?

Name _____ **Phone**_____ **Relationship**_____

PLEASE COMPLETE THE BACK OF THIS FORM

Patient Health History

MEDICAL HISTORY

Yes	No		Yes	No	
☐	☐	Rheumatic fever	☐	☐	Heart problems
☐	☐	Scarlet fever	☐	☐	Heart murmur
☐	☐	Mitral valve prolapse	☐	☐	High/low blood pressure
☐	☐	Asthma or breathing problems	☐	☐	Kidney problems
☐	☐	Epilepsy or seizures	☐	☐	Tuberculosis (TB)
☐	☐	Hepatitis, jaundice or liver problems	☐	☐	Diabetes
☐	☐	Cleft lip/palate	☐	☐	Endocrine or thyroid problems
☐	☐	Tonsils and/or Adenoids removed	☐	☐	Bone disorders
☐	☐	Speech or hearing problems	☐	☐	Radiation treatment
☐	☐	Anemia or bleeding disorders	☐	☐	Mental health or behavioral problems
☐	☐	Sinus or allergies	☐	☐	HIV/AIDS
☐	☐	Latex Allergy	☐	☐	Sexually transmitted disease

If you have ever had any type of surgery, please describe: _____
If you are allergic to any medications, please list: _____
If you are taking any prescription or over-the-counter drugs, please list:
_____
If you are currently under a physician's care for any medical condition, please give doctor's name and describe condition: _____
Females: Is there any chance that you may be pregnant? ____ If yes, how far along? _____

DENTAL HISTORY

Yes	No		Yes	No	
☐	☐	Trauma to the teeth and/or face	☐	☐	Frequent cold sores
☐	☐	Finger/thumb sucking habit	☐	☐	Periodontal disease/treatment
☐	☐	Cheek or lip biting	☐	☐	Click or pop of jaw joints
☐	☐	Clench or grind teeth	☐	☐	Jaw pain
☐	☐	Mouth breather	☐	☐	Pain around the ear
☐	☐	Bleeding gums	☐	☐	Frequent headaches
☐	☐	Sensitive teeth	☐	☐	Smoking

☐ ☐ Aware or concerned about over or under developed jaw?
☐ ☐ Are there any family members with similar tooth or jaw relationship?
☐ ☐ Are you concerned about the appearance of your teeth?
☐ ☐ Have you ever been told that you need to take antibiotics before dental treatment?

What is your main orthodontic concern? _____
If you have had previous orthodontic consultation and/or treatment, please describe:
_____
If there have been any injuries to the face, mouth, teeth or chin, please describe:
_____
Date of last dental visit _____How often does patient visit the dentist? _____

I have read and understand the above questions. The information that I have given is correct to the best of my knowledge. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history or medical/dental status I will inform this practice.

_____ _____
Signature of patient Date