Michelle Dumiller Carlton, DDS
340 Veterans Boulevard
Denham Springs, LA 70726
225.664.9699
www.carltonortho.com

**Date** _____

## Patient Information

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

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

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

**Phone: Cell** _____ **Work** _____ **Email** _____

**Appointment Confirmation: We will electronically confirm appointments by email and text message.**

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

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

**Please list children and ages** _____

**General Dentist** _____ **Family Physician** _____

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

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## Orthodontic Insurance Information

**Primary policy holder's name** _____ **SS #** _____ **Birthdate** ____/____/____

**Insurance company name** _____ **Address** _____

**Phone** _____ **ID #** _____ **Employer / Group #** _____

**Secondary policy holder's name** _____ **SS #** _____ **Birthdate** ____/____/____

**Insurance company name** _____ **Address** _____

**Phone** _____ **ID #** _____ **Employer / Group #** _____

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## Emergency Information

**Who should we contact in case of an emergency?**

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

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**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 | ☐ | ☐ | Gastrointestinal disorders |
| ☐ | ☐ | Hepatitis, jaundice or liver problems | ☐ | ☐ | Tuberculosis (TB) |
| ☐ | ☐ | Cleft lip/palate | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Tonsils and/or Adenoids removed | ☐ | ☐ | Endocrine or thyroid problems |
| ☐ | ☐ | Speech or hearing problems | ☐ | ☐ | Bone disorders |
| ☐ | ☐ | Anemia or bleeding disorders | ☐ | ☐ | Radiation treatment |
| ☐ | ☐ | Sinus or allergies | ☐ | ☐ | Mental health or behavioral problems |
| ☐ | ☐ | Latex Allergy | ☐ | ☐ | HIV/AIDS |
| | | | ☐ | ☐ | 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 the 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