

# Dr. Nicholas S. Ising Orthodontist

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

Patient's Dentist \_\_\_\_\_

Patient's Physician \_\_\_\_\_

## Dental History

## Medical History

Prior orthodontic treatment?	Y	N	Any allergies to drugs, foods, or environment?	Y	N
If yes, when and where?	Y	N	Any birth defects?	Y	N
Any Periodontal (gum) problems?	Y	N	Any learning disabilities or ADD?	Y	N
Any permanent teeth removed?	Y	N	Thyroid disease?	Y	N
Any problems with your jaw joints?	Y	N	Bleeding disorder or Hemophilia?	Y	N
Thumb sucking or finger sucking?	Y	N	Diabetes?	Y	N
Any injuries to teeth or facial bones?	Y	N	Asthma?	Y	N
Mouth breathing or Snoring?	Y	N	Arthritis?	Y	N
Tongue thrusting?	Y	N	Heart Murmur or Mitral Valve Prolapse?	Y	N

If you answered yes to any of the questions please explain: \_\_\_\_\_  
 \_\_\_\_\_  
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 \_\_\_\_\_  
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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Artificial heart valve?	Y	N
Liver or Kidney disease?	Y	N
Cancer?	Y	N
Hepatitis?	Y	N
TB?	Y	N
HIV positive or AIDS?	Y	N
Growth disorder?	Y	N
Seizures?	Y	N
Tonsils or Adenoids problem?	Y	N
Latex Allergy?	Y	N
Prescription Medications?	Y	N

I have read and understand the above questions. I will not hold Dr. Ising or any member of her team responsible for any errors or omissions that I have made in the completion of this form; if there are any changes to this history record or dental/medical status I will inform this practice.

\_\_\_\_\_  
 Signature Date

**OFFICE USE ONLY:**

I have reviewed the above information and there are no changes; if there are changes I will inform this practice.

\_\_\_\_\_  
 Signature (responsible party) Date

I have reviewed the above information and there are no changes; if there are changes I will inform this practice.

\_\_\_\_\_  
 Signature (responsible party) Date