Cavanaugh Orthodontics, P.C.
Medical/Dental History Form

Patients Last Name:_____First:_____M.I._____ Date:_____
Date of Birth: _____ Age:_____Sex:_____Home Phone:_____
Patients Address:_____City:_____State:_____Zip:_____
Social Security # of Responsible Party:_____Phone #:_____
His/Her Address: _____City:_____State:_____Zip:_____
Parent/Guardians Last Name:_____
Patient is: Single:_____Married: _____Widowed:_____Separated: _____ Divorced_____
Name of Patients Dentist:_____Referred By:_____Family Members in Treatment:_____
Patients School:_____Musical Instrument Played:_____
Sports, Hobbies & Avocations:_____
Fathers Last Name:_____First:_____Middle:_____
Address:_____City:_____State:_____Zip:_____
Occupation:_____Employer:_____Work Phone:_____
Mothers Last Name:_____First:_____Middle:_____
Address:_____City:_____State:_____Zip:_____
Occupation:_____Employer:_____Work Phone:_____
In case we cannot reach you: Person to contact _____Phone #_____

Medical History

Health Quality: ☐ Good ☐ Fair ☐ Poor Allergies: ☐ Food ☐ Drug ☐ Hayfever ☐ Asthma ☐ Other

Has the patient had any of the following: (Please Circle)

Hepatitis	Diabetes	Kidney Problems	Sinus Problems	Immune Disorder	Lip or Tongue Biting
Frequent Headaches	Heart Disease	Bleeding Gums	Arthritis	Speech Impairment	Nail Biting
Cerebral Palsy	Epilepsy	Liver Disease	Convulsions/Seizures	Tonsils/Adenoids	Tuberculosis
Rheumatic Fever	Excessive Bleeding	Cold Sores/Fever Blisters	Throat Infections	Mouth Breathing	Hemophilia
Frequent Colds	Thyroid Problems	Dizziness or Fainting	Grinding of Teeth	Thumb/Finger Sucking	Difficult Breathing
Latex Sensitivity	Artificial Joints	AIDS/HIV	Radiation Therapy	Chemotherapy	Other

Please Explain:_____
Physician:_____Under Physician's Care at Present? (Y or N)_____
For What:_____
List Drugs Regularly Taken & Reason:_____

Dental History

Last Dental Visit:_____Dental Work Being Done Now?_____If Yes What?_____
Has Patient Ever Received a Blow to the Teeth or Jaw?_____If Yes, Explain:_____
Has the Patient had Orthodontic Treatment or Evaluation?_____If Yes, By Whom?_____
What do you feel are the Orthodontic Problems? ☐ Alignment of Teeth ☐ Dental Protrusion ☐ Facial Features ☐ Other
_____
Who First Noticed the Need for Orthodontic Treatment?_____
Additional Comments:_____

Orthodontic Insurance

Primary	**Secondary**
Orthodontic Coverage:_____	Orthodontic Coverage:_____
Insurance Co. Name: _____	Insurance Co. Name:_____
Insurance Co. Address:_____	Insurance Co. Address:_____
Insurance Co. Phone #:_____	Insurance Co. Phone #:_____
Group # (plan or policy #):_____	Group # (plan or Policy #):_____
Lifetime Maximum Benefit:_____	Lifetime Maximum Benefit:_____
Insured's Name:_____	Insured's Name:_____
Insured's Relation to Patient:_____	Insured's Relation to Patient:_____
Insured's Date of Birth:_____	Insured's Date of Birth:_____
Insured's Employer:_____	Insured's Employer:_____

I certify that I have answered the above questions to the best of my ability. I will not hold Cavanaugh Orthodontics, P.C. or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for any and all records taken, and will pay the cost of x-rays and other records taken at the time of consultation and/or diagnosis.

_____ _____ Signature of
Patient (Parent or Guardian if Patient is a Minor) Date