plaza orthodontics

JAMES W. KOHL AND ASSOCIATES

WELCOME

To help us learn more about you, please fill out both sides of this form completely.
This information, which is important for our records and your health, is confidential.
The better we communicate, the better we can care for you.

ABOUT YOU

Name:_____I prefer to be called:_____

Age:_____Birth date:___/____/____Sex:____ Home Phone:_____

Home Address:_____
STREET CITY ZIP

Cell Phone:_____ Business Phone :_____

E Mail address _____

Where and when are the best times to reach you?_____

Employer:_____Occupation:_____

Employer's Address:_____
STREET CITY ZIP

Referred by:_____

General Dentist:_____Last Visit Date:_____

Other family members seen by us:_____

Person responsible for account:_____Relationship:_____

Address:_____
(IF DIFFERENT FROM ABOVE) STREET CITY ZIP

Home Phone:_____Business Phone:_____

Email Address: _____ Cell Phone: _____

MEDICAL HISTORY

Have you ever had the following?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Arthritis
Y N Artificial Valves / Joints
Y N Sinus Problems
Y N Allergies (Seasonal)
Y N Allergies to Medications
Y N Metal Allergies (Nickel)
Y N Latex Allergies
Y N High / Low Blood Pressure
Y N Severe / Frequent Headaches
Y N Emotional Problems
Y N Epilepsy / Seizures
Y N Diabetes / Tuberculosis
Y N Blood Disorders
Y N Endocrine Problems
Y N Hepatitis
Y N Hearing Disorders
Y N Prescription for Bone Health
If yes please list:_____

Your current physical health is:
☐Good ☐Fair ☐Poor
Physician:_____
Phone #:_____
Present Medications:_____
_____

DENTAL HISTORY

Reason for Visit:_____
_____

Have you ever had the following?

Y N Previous Orthodontic Evaluation
Date:_____
Y N Previous Orthodontic Treatment
Date:_____
Y N Pain / Discomfort in Jaw Joint (TMJ / TMD)
Y N Injury to the Face or Jaw
Y N Injury to the Teeth
Y N Grinding of the Teeth
Y N Clenching of the Teeth
Y N Tongue Thrusting
Y N Mouth Breathing
Y N Nail Biting / Chewing Habits
Y N Sleep Apnea
Y N Snoring
Y N Difficulty with Extractions / Other Dental Treatment
Y N Numerous Cavities
Y N Periodontal Disease
Y N Speech Problems

Your current dental health is:
☐Good ☐Fair ☐Poor
Additional Comments / Explanations:_____
_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE DATE

Thank you for filling out this form completely.