WELCOME TO DR. LOWDER'S OFFICE! (Adults)

We strive to make your visit pleasant and educational.
Our goal is to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOU

Today's Date:___/___/_____ □ Male □ Female
Name:_____
Last First MI
I prefer to be called:_____ Age:_____
Birthdate:___/___/___ SS#:_____
Home #:_____ Cell #:_____
Home Address:_____
_____
City State Zip
Email Address:_____
When and where are the best times to reach you?_____
_____
Other Family Members Seen By Us:_____
_____
Are you responsible for the account? □ Yes □ No
Marital Status: □ Married □ Single □ Divorced □ Other

ABOUT YOUR EMPLOYER

Name:_____ Years employed:_____
Work Phone:_____ Occupation:_____
Address:_____

YOUR DENTIST

Name:_____ Last Visit:_____
City, State:_____ Phone: _____
Whom may we thank for referring you?_____

SPOUSE'S INFORAMTION

Name:_____ Birthdate:_____
Address:_____
Employer:_____ SS#:_____
Work #:_____ Home#:_____
Email Address:_____ Cell #:_____
Responsible For Account? □ Yes □ No

RESPONSIBLE PARTY

Name:_____ Birthdate:_____
Address:_____
Employer:_____ SS#:_____
Work #:_____ Home#:_____
Email Address:_____ Cell #:_____
Responsible For Appointments? □ Yes □ No

PRIMARY DENTAL INSURANCE

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____
Group/Policy #:_____
Orthodontic Coverage? □Yes □ No
Insured's Name:_____
Relationship to Patient:_____
Insured's Birthdate:_____
Insured's Employer:_____
Insured's SS#:_____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____
Group/Policy #:_____
Orthodontic Coverage? □Yes □ No
Insured's Name:_____
Relationship to Patient:_____
Insured's Birthdate:_____
Insured's Employer:_____
Insured's SS#:_____

MEDICAL HISTORY

Family Medical History

Do your parents or siblings have any of the following health problems? If so, please explain.
Bleeding disorders_____
Diabetes_____
Arthritis _____
Metabolic Disturbance_____
Severe allergies_____
Unusual dental problems_____
Jaw size imbalance_____
Any other family medical condition we should no about?
_____

Patient Profile

□yes □no □dk/u Do you comply with directions well?
□yes □no □dk/u Do you brush teeth conscientiously?
□yes □no □dk/u Are you sensitive or self-conscious about teeth?
□yes □no □dk/u Do you have learning disabilities or need extra help with instructions?
□yes □no □dk/u Currently have or had substance abuse problems
□yes □no □dk/u Do you chew or smoke tobacco?
□yes □no □dk/u Operations? Describe:_____
□yes □no □dk/u Hospitalized? Describe:_____
□yes □no □dk/u Being treated by other health care professional? For:_____
What is physician's name and phone?_____

For medical and dental history questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation. **SEE OTHER SIDE**

Now or in the past, have you had:

□yes □no □dk/u Abnormal bleeding or bruising- anemia?
□yes □no □dk/u ADD/ ADHD?
□yes □no □dk/u Any hospital stays?
□yes □no □dk/u Any operations?
□yes □no □dk/u Artificial bones, joints, valves?
□yes □no □dk/u Arthritic or Rheumatoid conditions?
□yes □no □dk/u Asthma?
□yes □no □dk/u Birth defects or hereditary problems?
□yes □no □dk/u Bone fractures, any major accidents?
□yes □no □dk/u Cancer, tumors, or radiation or chemotherapy?
□yes □no □dk/u Chest pain, short of breath or swelling ankles?
□yes □no □dk/u Cardiovascular/blood pressure problems?
□yes □no □dk/u Congenital heart defects, heart murmur?
□yes □no □dk/u Eating disorder?
□yes □no □dk/u Eye, ear, nose, or throat condition?
□yes □no □dk/u Convulsions, epilepsy, or neurological problems?
□yes □no □dk/u Frequent headaches, colds, or sore throats?
□yes □no □dk/u Diabetes?
□yes □no □dk/u Handicaps, disabilities, depression?
□yes □no □dk/u Hearing impairment?
□yes □no □dk/u Hemophilia?
□yes □no □dk/u Hepatitis, Jaundice, or liver problem?
□yes □no □dk/u HIV+/AIDS?
□yes □no □dk/u Immune system problems (Lupus, etc)?
□yes □no □dk/u Kidney problems?
□yes □no □dk/u Phen-Fen use?
□yes □no □dk/u Osteoporosis
□yes □no □dk/u Rheumatic/ Scarlet fever?
□yes □no □dk/u Skin disorder?
□yes □no □dk/u Speech, vision, taste, hearing difficulties?
□yes □no □dk/u Stomach ulcers or hyperacidity?
□yes □no □dk/u Tuberculosis (TB), polio, pneumonia, mono?
□yes □no □dk/u Other Medical condition or symptoms?
Describe:_____

Allergies or reactions to any of the following:

□yes □no □dk/u Local Anesthetic
□yes □no □dk/u Pain Medications (Aspirin, Ibuprofen, Codeine)
□yes □no □dk/u Antibiotics (Penicillin, etc) or Sulfa
□yes □no □dk/u Metals (jewelry)
□yes □no □dk/u Latex (gloves, balloons), vinyl or acrylic
□yes □no □dk/u Seasonal substances (hayfever, asthma, sinus)
□yes □no □dk/u Other substances (specify)_____

WOMEN ONLY

□yes □no □dk/u Are you pregnant?
□yes □no □dk/u Are you anticipating becoming pregnant?

Medications

□yes □no Do you take bisphosphonates such as Fosamax?
□yes □no □dk/u Are you taking medications, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication_____Taken for_____
Medication_____Taken for_____
Medication_____Taken for_____

DENTAL HISTORY

Now or in the past, have you had:

□yes □no □dk/u Evaluation for **or** received orthodontic treatment?
□yes □no □dk/u History of any extra or missing teeth?
□yes □no □dk/u Permanent or extra teeth removed?
□yes □no □dk/u Extra or congenitally missing teeth?
□yes □no □dk/u **Injuries or trauma (chips, fractures, etc) to the face, mouth, teeth, or chin?**
□yes □no □dk/u Food impacted between teeth?
□yes □no □dk/u Mouth infections, bleeding, bad breath?
□yes □no □dk/u Gum boils, cold sores, canker sores
□yes □no □dk/u Adenoids or tonsils been removed?
□yes □no □dk/u Periodontal "gum" problems or treatment?
□yes □no □dk/u Fluoride supplements or fluoridated water?
□yes □no □dk/u Any teeth irritating cheek, lip, tongue, or palate?
□yes □no □dk/u Difficult problems associated with dental work?
□yes □no □dk/u Difficulty eating or swallowing?
□yes □no □dk/u History of speech swallowing problems?
□yes □no □dk/u Been under another dentist's care?
□yes □no □dk/u Difficulty in chewing or opening jaw?
□yes □no □dk/u Treatment for "TMD" or "TMJ" problems?
□yes □no □dk/u **Have you ever had any clicking, popping, pain, or tenderness in jaw joints (TMJ/TMD)?**

Do/did you have any of the following habits (circle Y or N)?

Y	N	Speech problems	Y	N	Lip sucking/ biting
Y	N	Nursing bottle	Y	N	Clenching/grinding teeth
Y	N	Mouth breathing	Y	N	Thumb/finger sucking
Y	N	Nail/object biting	Y	N	Tongue Thrust

□yes □no Are you currently in pain?
□yes □no Do you like your smile?
□yes □no Do you brush teeth daily?
□yes □no Do you floss teeth daily?
□yes □no Do your gums bleed when brushing or flossing?
□yes □no Are you ware of loose, broken or missing fillings?
□yes □no Is there any dental work that still needs to be done?
□yes □no Would you object to wearing braces if indicated?
□yes □no Any other information we should know? **Please explain:**

What is your primary concern? _____
How often do you brush:_____Floss:_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical or dental status, I will so inform this practice. I authorize the dental staff to perform the necessary dental/orthodontic services that may be need.

Signed:_____Date signed:_____
(Parent or Guardian)

Signed:_____Date signed: _____
(Dental staff member)