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(978) 465-2201

## ADULT HISTORY

### PATIENT INFORMATION/CLINICAL HISTORY *(please complete in ink)*

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

Home address \_\_\_\_\_ Tel # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_ Cell phone # \_\_\_\_\_ SS# \_\_\_\_\_

**Best number to call during business hours** \_\_\_\_\_

Do you have Orthodontic Insurance? \_\_\_ Yes \_\_\_ No

Name of Insurance Company \_\_\_\_\_ State \_\_\_\_\_

ID# \_\_\_\_\_ Group, plan or Policy# \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_ Employer Telephone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Please describe why you sought this consultation \_\_\_\_\_

Y / N Have you ever been treated for this problem before? If yes, describe \_\_\_\_\_

Y / N Has any other member of the family been a patient in this office? \_\_\_\_\_

Name \_\_\_\_\_

### **Spouse Information:**

Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's address \_\_\_\_\_ Work Tel# \_\_\_\_\_

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

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

If responsible party is other than the patient, please give information:

Name \_\_\_\_\_ SS# \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Tel# \_\_\_\_\_

Does responsible party have Orthodontic Insurance? \_\_\_ Yes \_\_\_ No

Name of Insurance Company \_\_\_\_\_ State \_\_\_\_\_

ID# \_\_\_\_\_ Group, plan or Policy# \_\_\_\_\_

**MEDICAL HISTORY: Have you had or do you have any of the following?**

- |                             |                           |   |                         |
|-----------------------------|---------------------------|---|-------------------------|
| Y / N Mitral Valve Prolapse | Y / N Scarlet Fever       | Y / N Congenital Heart Defect                   | Y / N Heart Murmur      |
| Y / N Rheumatic Fever       | Y / N High Blood Pressure | Y / N Hemophilia                                | Y / N Blood Disorder    |
| Y / N AIDS/HIV Infection    | Y / N Hepatitis           | Y / N <b>Allergies (latex, nickel, plastic)</b> | Y / N Diabetes          |
| Y / N Herpes (Any type)     | Y / N ADD/ADHD            | Y / N Hearing Impairment                        | Y / N Artificial joints |
| Y / N Arthritis             | Y / N Epilepsy            | Y / N Mental Health Problems                    | Y / N Headaches         |
| Y / N Sleep Apnea           | Y / N Cancer              |   |                         |

Please list any other significant information regarding your medical history:

\_\_\_\_\_

\_\_\_\_\_

Y / N Are you currently under a physician's care? If yes, reason \_\_\_\_\_

Y / N Are you currently taking any medications? If yes, describe \_\_\_\_\_

Y / N Are you allergic to any medications? (aspirin, penicillin, etc.) If yes, what? \_\_\_\_\_

**Y / N Do you need to be pre-medicated before dental work?**

**FEMALE PATIENTS:**

Y / N Have you experienced menopause?

Y / N Has anyone in your family had osteoporosis?

Y / N Is there a possibility that you could be pregnant?

**DENTAL HISTORY:**

Y / N Do any of your teeth hurt? If yes, upper or lower, right or left? \_\_\_\_\_

Y / N Have wisdom teeth been removed? How many? \_\_\_\_\_

Y / N Have you ever had treatment for a periodontal disease (gum disease)? If yes, please describe: \_\_\_\_\_

Y / N Have you ever had previous orthodontic treatment (braces)? If yes, when and with whom? \_\_\_\_\_

Y / N Have you had any injuries to your mouth or teeth? If yes, describe \_\_\_\_\_

Y / N Have you had any injuries to your head or neck area? If yes, describe \_\_\_\_\_

Y / N Do you now or have you ever experienced pain or discomfort in your jaw joint?

If so, \_\_\_ Right \_\_\_ Left \_\_\_ Both Since when \_\_\_\_\_

During what activity \_\_\_\_\_

Y / N Do you hear any clicking (popping) in your jaw joints?

If so, \_\_\_ Right \_\_\_ Left \_\_\_ Both Since when \_\_\_\_\_

During what activity \_\_\_\_\_

Y / N Do you clench or grind your teeth? If yes, when? \_\_\_\_\_

Y / N Have you experienced any problems with previous dental treatment? \_\_\_\_\_

Do you have any of the following habits?

- |                           |                   |                      |                        |
|---------------------------|-------------------|----------------------|------------------------|
| Y / N Finger/Thumbsucking | Y / N Nail Biting | Y / N Ice chewing    | Y / N Smoking or using |
| Y / N Lip Biting          | Y / N Gum chewing | Y / N Mouth breather | other tobacco products |

We recognize that patients sometimes have concerns that may not be addressed by the questions in this Clinical History Form. Please feel free to include any additional information regarding your clinical history.

\_\_\_\_\_

\_\_\_\_\_

I understand that the above medical and dental information is correct. If there are any changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

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

\_\_\_\_\_  
Doctor's Signature Date