

John Mark Griffies, DDS, PLLC
dba Straighten-Up Orthodontics
Patient's Clinical History/Adults

Name _____ Age _____ Sex _____ Date of Birth _____
Last First M.I. Mo / Day / Yr

Address _____ Tel.#() _____
Street City Zip

S.S.# of Patient _____

Best telephone number to call for appointments (During Business Hours) _____

Best Fax # _____ Best Cell Phone # _____ Best E-mail address _____

Employed by _____ Occupation _____ Position _____
 Office Address _____ Work Tel # _____

Do you have Orthodontic Insurance? ___ Yes ___ No Name of Insurance Co. _____
 Group Policy Number. _____

Do you have Medical Insurance? ___ Yes ___ No Name of Insurance Co. _____

Spouse's Name _____
Last First M.I.

Patient's Family Dentist _____

Patient's Family Physician _____

Whom may we thank for referring you to our office? _____

MEDICAL HISTORY:

Have you had or do you have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pains	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nerve or Brain Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Blood Vessel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Any type)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Herpes (Any type)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Are you Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to Latex	<input type="checkbox"/>	<input type="checkbox"/>			

Comments _____

Please list any other significant information about your medical history:

Yes No

- Are you under a physician's care at present? If yes, reason _____
- Are you presently, or have you ever been, under the care of a psychiatrist or psychologist? If yes, describe _____
- Are you currently taking any medication? If yes, describe _____
- Are you allergic to any medications? (Eg. Aspirin, penicillin, etc.) If yes, what? _____
- Have you ever had any general anesthesia? When and why? _____

DENTAL HISTORY:

Yes No

- Do any of your teeth hurt? If yes, upper right upper left lower right lower left
- Have any wisdom teeth been removed? How many? _____
- Have any other teeth been removed? If yes, describe _____
- Have you ever had treatment for periodontal disease (gum disease)? If yes, describe _____
- Have you ever had any previous orthodontic treatment (braces)? If yes, when _____
If yes, doctor's name and address _____
If yes, were they removed prior to completion? Yes No If yes, describe why they were removed early _____
- Have there been any injuries to your mouth or teeth? If yes, describe _____
- Have you ever had any injury in the head and neck area? If yes, describe _____
- Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe _____
- Have you ever had any surgery in the head and neck area? If yes, describe _____
- Do you clench or grind your teeth? If yes, while sleeping under stress other _____
- Do your jaw muscles ever feel tired? If yes, explain _____
- Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe _____
- Does it hurt to chew? If yes, where does it hurt? _____
- Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
<input type="checkbox"/> Clicking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Grating	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Did these joint sounds begin gradually or suddenly? Gradually Suddenly
- Was there some specific event that started the joint sounds? If yes, describe _____
- Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____
- Have your jaws ever "locked" closed? If yes, describe _____
- Have your jaws ever "locked" wide open? If yes, describe _____
- Do you have pain in you jaw joints? If yes, right left Since when? _____
- Did your pain start gradually or suddenly? Gradually Suddenly
During what activity? _____ Describe nature of pain _____
What increases the pain? _____ What decreases the pain? _____

Do you have any of the following habits?

Yes No

- Finger/Thumbsucking
 - Lip Biting
 - Nail Biting
 - Gum Chewing
 - Ice Chewing
 - Has any other member of the family had orthodontic treatment?
 - Has any other member of the family been a patient in this office?
- Name(s)_____

Please describe why you sought this consultation _____

Yes No

- Have you ever been treated for this problem before? If yes, please describe the diagnosis and treatment _____
- _____

Any information you can give me concerning yourself will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies: _____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

(your signature) Date

Doctor's Notes _____

(Doctor's Signature) Date

SIGNATURE PAGE

PATIENT NAME: _____

DATE: _____

I HAVE READ AND UNDERSTAND THE POLICY TOWARD VISITING YOUR DENTIST AND USING A PRESCRIPTION FLUORIDE EVERY NIGHT.

PATIENT SIGNATURE: _____

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES OF DR. GRIFFIES AND STRAIGHTEN-UP ORTHODONTICS.

PATIENT SIGNATURE: _____

I HAVE READ AND UNDERSTAND THE PRIVACY NOTICE AND PRIVACY AUTHORIZATION FOR DR. GRIFFIES AND STRAIGHTEN-UP ORTHODONTICS.

PATIENT SIGNATURE: _____

I HAVE READ AND UNDERSTAND THE LETTER OF INFORMATION AND CONSENT AGREEMENT FOR ORTHODONTICS AND ALL OF MY QUESTIONS PERTAINING TO THE ORTHODONTIC TREATMENT PROPOSED HAVE BEEN ANSWERED.

PATIENT SIGNATURE: _____