James A. Hinesly, D.D.S., M.S., P.C.

ORTHODONTICS

specialist in orthodontics and dentofacial orthopedics for children and adults

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Dental-Medical History

ADULT DENTAL AND MEDICAL HISTORY

Date ______________________

Name ______________________________________ Date of Birth ______________ Age __________
(first) (middle) (last)

Address ______________________________ City ______________________________ Zip ________

Telephone (Home) ______________ Business (phone) ______________________________

Dentist ______________________ City ______________________ Phone ______________

Physician ______________________ City ______________________ Phone ______________

Employed by ______________________________ Occupation ______________________

Address ______________________________ Social Security No. ______________________

Dental Insurance Information ______________________________ Group No. ______________

Single ________ Married ____________ Widowed ____________ Divorced ____________ Children ____________

Spouses Name ______________________________ Occupation ______________________

Employed by ______________________ City ______________________ Social Security No. ______________

Dental Insurance Information: Name ______________________________ Group No. ______________

MEDICAL HISTORY

General Health: Good ______________________ Fair ______________________ Poor ______________________

Presently under medical care for ____

Birth defects ____

Medications currently being taken (drug and dose) ____

Allergic to any medication ____

Please check yes or no to the following and date:

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
Adopted Child	❑	❑	______	Ear/nose infections	❑	❑	______	Glaucoma	❑	❑	______	Rheumatic fever	❑	❑	______
Adenoids (removed)	❑	❑	______	Emotional	❑	❑	______	**Hepatitis**	❑	❑	______	**Scoliosis**	❑	❑	______
								Heart Murmur	❑	❑	______				
								Hospitalized	❑	❑	______				
Allergies	❑	❑	______	Endocrine disorder	❑	❑	______					Speech difficulty	❑	❑	______
								Hyperactivity	❑	❑	______				
Blood/Bleeding Problems	❑	❑	______	Epilepsy	❑	❑	______					Tonsils (removed)	❑	❑	______
Bone disorder	❑	❑	______					Learning Disability	❑	❑	______				
Diabetes	❑	❑	______	Fainting Spells	❑	❑	______	Liver disorder	❑	❑	______	Venereal disease	❑	❑	______

Other ____

Please give any additional information or details where necessary ______________________________

DENTAL HISTORY

Date of last dental check-up ____

Injury or trauma to the face or teeth ____

Bruxism: (grinds teeth) Yes ______________ No ______________ at night ______________ daytime ______________

Jaw point (TMJ problems) noise ______________ pain ____________ earaches/ringing ______________ soreness & stiffness ______________

Speech: difficulty in pronunciation Yes ______________ No ______________ Speech lessons Yes ______________ No ______________

Describe major reason for seeking orthodontic treatment ____

____

Other family members with similar dental conditions ____

Other family members with orthodontic treatment ____

Have you had any experience with or seen another orthodontist? No ______________________ Yes ______________

Name ____

Any additional comments ____

How and when did you hear about our office? ____

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