

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

ORTHODONTICS

specialist in orthodontics and dentofacial orthopedics for children and adults



126 Herrick Park Dr.
Tecumseh, MI 49286
Phone: (517) 423-6300
Fax: (517) 423-9735

2433 Oak Valley Drive
Suite 200
Ann Arbor, MI 48103
Phone: (734) 769-7600

Dental-Medical History

ADULT DENTAL AND MEDICAL HISTORY

Date _____

Name _____ (first) _____ (middle) _____ (last) Date of Birth _____ Age _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ear/nose	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	_____	infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
(removed)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____	Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____	disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tonsils (removed)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning	<input type="checkbox"/>	<input type="checkbox"/>	_____	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	_____	Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____					Liver disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____				

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? _____