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www.kendrickorthodontics.com

James Kendrick, D.M.D., P.A.

Orthodontics and Temporomandibular Joint Disorders

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Patient's Clinical History/Family Information
(Please complete in ink)

Date_____

Patient's Name_____ Age_____ Gender_____ Birth Date_____
Last First M.I.

Address _____Tel. # ( ) _____
Street City Zip

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

Best Fax# ( ) _____ Best Cell Phone # ( ) _____ Best E-mail Address_____

Employed by _____ Occupation _____ Position _____

Employer Address _____ Work Tel. # ( ) _____

Social Security Number of Patient **(for accounting purposes only)** _____-_____-_____

□ Single □ Married □ Separated □ Divorced □ Widowed □ Partnered

Orthodontic Insurance? □Yes □No Name of Insurance Company _____ ID# _____ Group # _____

Medical Insurance? □Yes □No Name of Insurance Company _____ ID# _____ Group # _____

Spouse Name_____ Gender_____ Birth Date_____
Last First M.I.

Employed by _____ Occupation _____ Position _____

Employer Address _____ Work Tel. # ( ) _____

Social Security Number of Spouse **(for accounting purposes only)** _____-_____-_____

Orthodontic Insurance? □Yes □No Name of Insurance Company _____ ID# _____ Group # _____

Medical Insurance? □Yes □No Name of Insurance Company _____ ID# _____ Group # _____

Patient's Family Dentist _____

Patient's Family Physician _____

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

Responsible party (if other than the patient/spouse): □ Not Applicable

Name _____ S.S. # _____-_____-_____ Birth Date _____ Relationship to patient _____

Home Address _____ Tel. # ( ) _____

Orthodontic Insurance? □Yes □No Name of Insurance Company _____ ID# _____ Group # _____

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Medical Insurance? □Yes □No Name of Insurance Company _____ ID# _____ Group # _____

MEDICAL HISTORY:

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

Yes / No		Yes / No	
□	□ Rheumatic Fever	□	□ Diabetes
□	□ Heart Murmur	□	□ Ulcers
□	□ High Blood Pressure	□	□ Psoriasis
□	□ Heart Attack/Stroke	□	□ Cancer
□	□ Blood Vessel Disease	□	□ Bone Disorders
□	□ Blood Disorder	□	□ Arthritis
□	□ AIDS/HIV Infection	□	□ Artificial Joints
□	□ Hepatitis	□	□ Sleep Apnea
□	□ Herpes (Any type)	□	□ Ear Disorder
□	□ Persistent Headaches	□	□ Sinus Infection
□	□ Neck Pains	□	□ Swollen Glands
□	□ Nerve or Brain Disease	□	□ Allergies
□	□ Migraine	□	□ Epilepsy
□	□ Mental Health Problems		

Comments:_____
_____

Please list any other significant information about your medical history:_____
_____

Yes / No

□ □ Are you under a physican'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?_____
_____

FEMALE PATIENTS:

Yes / No

□ □ Do any of your teeth hurt? If yes, □ upper right □ upper left □ lower right □ lower left

□ □ Do you have regular menstrual cycles?

□ □ Have you experienced menopause?

□ □ Does anyone in your family have osteoporosis?

□ □ Is there any possibility that you could be pregnant?

DENTAL HISTORY:

Yes / No

□ □ Have you ever had any general anesthesia? When?_____

□ □ Have any wisdom teeth been removed? How many?_____

□ □ Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe:_____
_____

□ □ Have there been any injuries to your mouth or teeth? 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, when_____

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□ □ Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe_____
_____
□ □ Have you ever had any injury in the head and neck area? If yes, describe_____
□ □ Does it hurt to chew? If yes, where does it hurt?_____
□ □ Do you have pain in your 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?_____
□ □ Was there some specific event that started the joint sounds? If yes, describe_____
□ □ Did these joint sounds begin gradually or suddenly? □ gradually □ suddenly
□ □ Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe: □ Right □ Left
Since when_____ During what activity_____
□ □ Clicking: □ □ Grating:
□ □ 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_____
What decreases the pain?_____
□ □ Do you have any of the following habits?
□ Finger / Thumbsucking □ Lip Biting □ Nail Biting □ Gum Chewing
□ Ice Chewing □ Smoking or using other tobacco products

Yes / No
□ □ Have you ever had any previous orthodontic treatment (braces)? If yes, when
If yes, Doctor's name_____ Doctor's Telephone number _____
Doctor's address_____
Please describe why you sought this
consultation:_____
_____
□ □ Have you ever been treated for this problem before? If yes, please describe the diagnosis and treatment.
□ □ Have any other members of the family had orthodontic treatment?
□ □ Have any other members of the family been a patient in this office?
Name: _____

We recognize that patients sometimes have specific concerns that may not be addressed by the question in this Clinical History Form. Please feel free to include any other information regarding your clinical history, or any other concerns that you may have, in the space below. If necessary, please add another sheet of paper.
_____
_____
_____
_____

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 my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____
(Signature of Patient) (Date)
Doctor's Notes
_____
_____
_____
_____

_____ _____

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(Doctor’s Signature) (Date)