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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

School _____ Grade _____ SS# _____-_____-_____

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

Best Fax# ( ) _____Best Cell Phone # ( ) _____Best E-mail Address _____

Father's Name_____ SS#_____-_____-_____ Birth Date_____
Last First M.I. (for accounting purposes only)

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Partnered

Home Address _____ Home Tel. # ( )_____

Employed by _____ Occupation _____ Position_____
Office Address _____ Work Tel. # ( ) _____
Orthodontic Insurance? □Yes □No
Name of Insurance Company _____Tel. # ( ) _____ ID# _____Group # _____
Medical Insurance? □Yes □No
Name of Insurance Company _____Tel. # ( ) _____ ID# _____Group # _____

Mother's Name_____ SS#_____-_____-_____ Birth Date_____
Last First M.I. (for accounting purposes only)

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Partnered

Home Address _____ Home Tel. # ( )_____

Employed by _____ Occupation _____ Position_____
Office Address _____ Work Tel. # ( ) _____
Orthodontic Insurance? □Yes □No
Name of Insurance Company _____Tel. # ( ) _____ ID# _____Group # _____
Medical Insurance? □Yes □No
Name of Insurance Company _____Tel. # ( ) _____ ID# _____Group # _____

Responsible party (if other than the patients parent, Please give information): □ Not Applicable

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

Home Address _____ Tel. # ( ) _____
Orthodontic Insurance? □Yes □No Name of Insurance Company _____ ID# _____ Group # _____

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

Patient's Family Dentist _____Tel # ( ) _____

Patient's Family Physician _____Tel # ( ) _____

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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	☐	☐ 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_____
☐ ☐ 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?_____

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- □ □ 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

_____
_____
_____
_____

_____ _____

(Doctor's Signature) (Date)