Chatham Orthodontics
DR. TERILYN MCHUGH
ORTHODONTIST

ADULT MEDICAL/ORTHODONTIC INFORMATION

Patient Information

Name: First/ Middle/Last

Birth date: Month/Day/Year Patient Gender: Male ☐ Female ☐

Patient's Address: Street/ City/ Province/ Postal Code

Home Phone Cellular Phone Occupation

Place of Employment and Address Employment Telephone Number

How would you prefer to be contacted? Home Phone☐ Work Phone☐ Cellular Phone☐ Email☐

Whom may we thank for referring you to our office?

Other family members / friends who have been our patients: ______________________

In case of emergency, we should notify: Name and relationship Telephone Number

Spouse Information

First/ Middle/ Last Occupation

Place of Employment and Address Employment Telephone Number

Medical History

Are you being treated for any medical condition at present or have you been treated within the past year?
Yes ☐No☐ If yes please explain: ______________________

When was your last medical checkup? ______________________

Has there been any change in your general health in the past year? Yes ☐No☐
If yes please explain: ______________________

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ☐ No ☐
If yes, please explain: ______________________

Do you have any allergies to medications, latex/rubber products or other items? Yes ☐ No ☐
If yes please explain: ______________________

Do you require antibiotic pre-medication prior to dental work/cleanings? Yes ☐ No ☐

Have you ever had a peculiar or adverse reaction to any medicine or product?
If yes, please explain: ______________________

Do you have or have you ever had asthma? Yes ☐ No ☐

Do you have or have you ever had any heart or blood pressure problems? Yes ☐ No ☐

Do you have or have you ever had an artificial heart valve, an infection of the heart (ie: *infective endocarditis*), or a heart condition from birth (ie: congenital heart disease) or a heart transplant? Yes ☐ No ☐

Do you have a prosthetic or artificial joint? Yes ☐ No ☐

Do you have any conditions or therapies that could affect your immune system? (ie: leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?) Yes ☐ No ☐

Have you ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐

Do you have a bleeding problem or bleeding disorder? Yes ☐ No ☐

Have you ever been hospitalized for any illnesses or operations? Yes ☐ No ☐
If yes please explain: ______________________________

Have you ever had any of the following diseases/medical conditions? Please check off if yes:

Chest pain, angina ☐	Rheumatic fever ☐	Pacemaker ☐	Steroid therapy ☐	Seizures (epilepsy) ☐
Heart attack ☐	Mitral valve prolapse ☐	Lung disease ☐	Diabetes ☐	Kidney disease ☐
Stroke ☐	Heart murmur ☐	Shortness of breath ☐	Cancer ☐	Tuberculosis ☐
Stomach ulcers ☐	Arthritis ☐	Thyroid disease ☐	Drug/alcohol dependency ☐	Depression ☐

Osteoporosis medications (e.g. Fosamax, Actonel) ☐

Do you smoke or use tobacco products? Yes ☐ No ☐

If female, is there any possibility you are pregnant or are you breastfeeding? Yes ☐ No ☐
Due date for pregnancy: ______________________________

Patient Care Information

____

Name of Patient's Dentist | Name of Family Doctor | Telephone number of Family Doctor

Do you attend dental visits regularly: Yes ☐ No ☐ Frequency: Every 6 months ☐ 9 months 12 months ☐

What is the main reason that you are visiting our office? ______________________________

____

If you could change anything about your smile, what would it be? ______________________________

____

Do you have any of the following habits?

Clenching/grinding teeth	Yes ☐	No ☐	Nail biting	Yes ☐	No ☐	Lip sucking/biting	Yes ☐ No ☐
Speech therapy	Yes ☐	No ☐	Mouth breathing	Yes ☐	No ☐		
Finger or thumb habit	Yes ☐	No ☐	Is the habit still present	Yes ☐	No ☐	If not present, at what age did it cease: ______	

Have there been any injuries to your face, mouth or teeth in the past? Yes ☐ No ☐
If yes, at what age and where? ______________________________

Have you experienced any jaw joint noises, joint pain or limited jaw movement? Yes ☐ No ☐

Has an orthodontist previously been consulted? Yes ☐ No ☐
If yes, who has been previously consulted and when? ______________________________

Do you desire orthodontic treatment? Yes ☐ No ☐

Have you ever been informed that you have any missing/extra permanent teeth? Yes ☐ No ☐

Do you have insurance coverage for orthodontic treatment? Yes ☐ No ☐

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature ______________________________ Date ______________________________