



CARROLL & SUTTON

ORTHODONTICS

ORTHODONTIC CARE FOR CHILDREN AND ADULTS

Venice Office
4120 Woodmere Park Blvd, Suite 7
Venice, FL 34293
941-408-8542

Sarasota Office
1617 South Tuttle Ave, Suite 2B
Sarasota, FL 34239
941-366-1612

North Port Office
3045 Bobcat Village Center Rd
North Port, FL 34288
941-257-2000

Arcadia Office
7 N. Luther Ave.
Arcadia, FL 34266
863-494-1600

www.csorthodontics.com

Medical History Form

Name: _____ Home Phone: _____
 Address: _____ Cell Phone: _____
 City: _____ State: _____ Zip Code: _____
 Date of Birth: _____ Gender: _____
 Employer: _____ Occupation: _____
 Name of Spouse or Closest Relative: _____

If you would like to access your appointment and/or account information via our website, please provide your email address: _____

Orthodontic Insurance Information

Insured's Name: _____ Insured's Soc. Sec #: _____
 Insured's Date of Birth: _____ Insurance Co. Name: _____
 ID #: _____ Ins. Co. Phone #: _____
 Insurance Co. Address: _____

Do you have dual coverage? Yes No If yes:

Insured's Name: _____ Insured's Soc. Sec #: _____
 Insured's Date of Birth: _____ Insurance Co. Name: _____
 ID #: _____ Ins. Co. Phone #: _____
 Insurance Co. Address: _____

How did you hear about our office? _____

Family Dentist: _____ City _____ State _____

Date of your last cleaning: _____ Frequency of cleanings: 3months 6months

Have you had an unfavorable experience in a dental office? _____

If so, describe: _____

Have you ever received orthodontic treatment? _____ If so, by whom? _____

Reason for wanting an orthodontic consultation _____

HEALTH HISTORY

Are you in good health? Yes No

For the following questions, please circle yes (Y) or no (N). These answers are for our office's records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation and treatment planning.

- | | | | |
|-----|---|-----|-------------------------------------|
| Y N | Learning disabilities or need extra help with instructions? | Y N | ADD or ADHD |
| Y N | Birth defects or hereditary problems? | Y N | Are you adopted? |
| Y N | Tuberculosis, polio, mononucleosis, or pneumonia? | Y N | Diabetes? |
| Y N | Hepatitis, jaundice, or liver problem? | Y N | Rheumatoid or arthritic conditions? |
| Y N | Seizures, epilepsy, fainting spells, or neurological problems? | Y N | Endocrine or thyroid problems? |
| Y N | Mental health disturbance or depression? | Y N | Cancer, tumor, radiation treatment? |
| Y N | Vision, hearing, taste, or speech difficulties? | Y N | Acid Reflux |
| Y N | History of eating disorder, anorexia or bulimia? | Y N | HIV or AIDS? |
| Y N | Excessive bleeding or bruising tendency, anemia, or bleeding disorder? | Y N | Problems of the immune system? |
| Y N | Cardiovascular problems such as shortness of breath, angina, heart attack? | Y N | High or low blood pressure? |
| Y N | Heart murmur, rheumatic fever, inborn heart defects, artificial heart valves? | Y N | Allergies or asthma? |
| Y N | Ear, nose, throat, tonsil or adenoid conditions? | Y N | Osteoporosis? |

Allergies or reactions to any of the following:

- Y N Aspirin or Ibuprofen?
Y N Penicillin or other antibiotics?
Y N Acrylic
Y N Metals (jewelry, clothing snaps, **nickel**)?
Y N **Latex** (gloves)?
Y N Local anesthetics (Lidocaine)
Y N Other substances: _____

Please list any medications, nutrient supplements, or non-prescription medicine that you are currently taking: _____

Y N Please list any operations or hospitalizations: _____
Y N Being treated by another health care professional? For _____

For Women Only:

- Y N Are you pregnant?
Y N Are you planning on getting pregnant?

Dental History:

- | | | | |
|-----|--|-----|--|
| Y N | Congenitally missing teeth or any permanent teeth removed? | Y N | Extra or supernumerary teeth? |
| Y N | Teeth sensitive to hot or cold; teeth throb or ache? | Y N | Trauma or injury to permanent teeth? |
| Y N | Any grinding, clenching, clicking or locking? | Y N | Periodontal or gum problems? |
| Y N | Thumb or finger sucking habit? Until what age? _____ | Y N | Tongue thrusting? |
| Y N | Ever been treated for TMD or TMJ problems? | Y N | History of speech problems? |
| Y N | Any pain in jaw or face, ringing in the ears, or severe headaches? | Y N | Mouth breathing habit? |
| Y N | Any relative with similar tooth or jaw treatment? | Y N | Frequent canker sores or cold sores? |
| Y N | Ever been or currently being treated for periodontal disease? | Y N | Jaw fractures, cysts, or mouth infections? |

I have read and understand the above questions. I will not hold Carroll & Sutton Orthodontics, LLC responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform the practice.

Date

Patient's Name

Patient's Signature