

PETTY & DRAGSTREM

ORTHODONTICS

ADULT REGISTRATION AND HEALTH HISTORY

Name _____ Preferred Name _____

Birthdate _____ Cell Phone _____

Home Phone _____ Email Address _____

Home Address _____ City _____ Zip _____

Occupation _____

Marital Status (Circle One) Married Divorced Separated Single Widowed Partnership

Spouse/Partner's Name _____

Birthdate _____ Cell Phone _____

Occupation _____

Dentist _____ City _____

Reason For Consultation: _____

How did you hear about our office?: _____

THIS IS A TWO SIDED FORM

5455 WOLF ROAD
WESTERN SPRINGS IL 60558
708.246.4000
www.mypdsmile.com

bright smiling futures

4230 WESTBROOK DRIVE
AURORA IL 60504
630.851.6888
info@mypdsmile.com

DENTAL HISTORY

Approximate date of last dental check up _____

For what procedure? _____

Any outstanding recommended dental work? If yes please explain:

How often do you:
brush? _____

floss? _____

Have you had fluoride treatments? Yes No

IF NO PERTAINS TO THE FOLLOWING, CHECK NO , IF YOU CHECK YES PLEASE EXPLAIN:

Any history of oral habits? Yes No
i.e., THUMB/FINGER SUCKING, nail biting, chewing pencils or ice, etc.?

Anxiety toward dentistry? Yes No

Injuries to the mouth or teeth? Yes No

Mouth breathing/snoring at night Yes No

Unusual speech habits? Yes No

ANY OF THE FOLLOWING CONDITIONS PRESENT?
IF YES, PLEASE EXPLAIN:

Jaw joint problems? Yes No

Bruxing (tooth grinding)? Yes No

Tooth sensitivity? Yes No

Periodontal disease/Gum problems? Yes No

Tooth discoloration? Yes No

MEDICAL HISTORY

Approximate date of your last physical exam: _____

Were you found to be healthy? Yes No

If not please briefly explain: _____

Are you under a physician's care now? Yes No

For what? _____

Are you on medication now? Yes No

If yes, what medication? _____

Have you ever been hospitalized? Yes No

If yes, please explain: _____

Do you have any allergies? Yes No

If yes, please explain: _____

Women: Are you pregnant or do you expect to be pregnant during treatment? Yes No

PLEASE MARK EACH CONDITION YOU HAVE A HISTORY OF, OR BEEN EXPOSED TO:

- | | |
|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> ASD | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bladder Disorders |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hearing Disorders. | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Hormone/growth problems | <input type="checkbox"/> Kidney Disorders |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Liver Disorders |
| <input type="checkbox"/> Muscle disorders | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Thyroid Disorders | |

Is there anything not covered above that is important that I should know about for your health and well being? Yes No

Date: _____ Updated: _____

Signature: _____