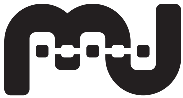

DR. MICHAEL A. JACK, D.D.S., M.S.

822 PORTAGE TRAIL • CUYAHOGA FALLS, OH 44221 • 330.929.2853

MEDICAL AND DENTAL INFORMATION
ADULT GENERAL INFORMATION

Date ____________________

Patient's Name ______________________________________ Home Phone (______) ______________________
Last First Middle

Age, in Years ________ Date of Birth ______ / _____ / _____ Sex M F Single _____ Married ____ Divorced ____ Separated _____
mo. day yr.

Address ______________________________________ Email ______________________________
Number,Street

City ______________________________________ State __________________ Zip Code _________________

Occupation ______________________________________ Social Security No. ______________________________

Employer ______________________________ Business Address ______________________________
Street City Stale Zip

Length of time employed with above employer: _______ Yrs. Business Phone (______) ______________________________

Name of Spouse ______________________________ Spouse's Age ______________________

Spouse's Occupation ____________________________ Business Address ______________________________ Business Phone (____) ____________

If you are completing this form for another person, what is your relationship to that person? ______________________________

In case of emergency, notify ______________________________ Telephone ______________________________

Referred by ______________________________

DENTAL INSURANCE INFORMATION

Subscriber Name ______________________________ ID. # ______________________________

Insurance Co. ______________________________ Group # ______________________________

Insurance Co. Address ______________________________ Insurance Co. Phone # __________________

MEDICAL HISTORY

The patient's Medical and Dental History information is very Important. This Information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Are you in good health? .... Yes No

2. Has there been any change in your general health within the past year? .... Yes No

3. Are you now under the care of a physician? .... Yes No

If so, what is the condition being treated? ______________________________

4. The name and address of my physician(s) is ______________________________

____

____

5. Are you taking any medicine(s) including non-prescription medicine? .... Yes No

If so, what medicine(s) are you taking? ______________________________

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? .... Yes No

If so, what was the illness or problem? ______________________________

Have Tonsils and Adenoids been removed? If yes, when? ______________________________ Yes No

7. Has patient had any Injuries to the face, head or teeth?
If yes, please give complete details including date(s) of occurrence, nature of injury and who treated: Yes No

____

____

____

8. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? .... Yes No

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) .... Yes No

1. Do you have pain in chest upon exertion? .... Yes No

2. Are you ever short of breath after mild exercise or when lying down? .... Yes No

3. Do your ankles swell? .... Yes No

4. Do you have inborn heart defects? .... Yes No

5. Do you have a cardiac pacemaker? .... Yes No

6. Have you ever had heart surgery? .... Yes No

c. Allergy .... Yes No

d. Sinus trouble .... Yes No

e. Asthma or hay fever .... Yes No

f. Fainting spells or seizures, dizziness .... Yes No

- **g.** Persistent diarrhea or recent weight loss .... Yes No
- **h.** Diabetes .... Yes No
- **i.** Hepatitis, jaundice or liver disease .... Yes No
- **j.** AIDS or HIV infection . ... Yes No
- **k.** Thyroid problems .... Yes No
- **l.** Respiratory problems, emphysema, bronchitis, etc. .... Yes No
- **m.** Arthritis or painful swollen joints .... Yes No
- **n.** Stomach ulcer or hyperacidity........ Yes No
- **o.** Kidney trouble. .... Yes No
- **p.** Tuberculosis........ Yes No
- **q.** Persistent cough or cough that produces blood........ Yes No
- **r.** Persistent swollen glands in neck .... Yes No
- **s.** Low blood pressure........ Yes No
- **t.** Sexually transmitted disease .. .. Yes No
- **u.** Epilepsy or other neurological disease .... Yes No
- **v.** Problems with mental health........ Yes No
- **w.** Cancer........ Yes No
- **x.** Problems of the immune system........ Yes No
- **y.** Alcoholism or drug dependency or addiction .... Yes No
  - **aa.** Scarlet Fever .... Yes No
  - **bb.** Chemotherapy .... Yes No
  - **cc.** Radiation Therapy. .... Yes No
  - **dd.** Cortisone Therapy .... Yes No
  - **ee.** Cosmetic Surgery .. .. Yes No
  - **ff.** Diabetes .... Yes No
  - **gg.** Rheumatism........ Yes No
  - **hh.** Epilepsy ... . Yes No
  - **ii.** Chicken Pox........ Yes No
  - **jj.** Fever Blisters........ Yes No
  - **kk**. Glaucoma .... Yes No
  - **ll.** Measles .... Yes No
  - **mm.** Mumps .... Yes No
  - **nn.** Nervousness/anxiety .... Yes No
  - **oo.** Psychological treatment .... Yes No
  - **pp.** Psychiatric Treatment .... Yes No
  - **qq.** Ulcers .... Yes No

9. Has patient had abnormal bleeding? .... Yes No

- **a.** Has patient ever required a blood transfusion .... Yes No

10. Does patient have any blood disorder such as anemia, hemophelia, leukemia, sickle cell disease? .. .. Yes No

- **a.** Does patient bruise easily .... Yes No

11. Has patient ever had any treatment for a tumor or growth? .... Yes No

12. Is patient allergic or have you had a reaction to:

- **a.** Local anesthetics .... Yes No
- **b.** Penicillin or other antibiotics .... Yes No
- **c.** Sulfa drugs........ Yes No
- **d.** Barbiturates, sedatives, or sleeping pills .... Yes No
- **e.** Aspirin .... Yes No
- **f.** Iodine.. .... Yes No
- **g.** Codeine or other narcotics. .... Yes No
- **h.** Other ____

13. Has patient had any problems associated with any previous dental treatment? .... Yes No

If so, explain ____

____

14. Does patient have any disease, condition, or problem not listed above that you think should know about? .... Yes No

If so, explain ____

____

15. Is patient wearing contact lenses?........ Yes No

16. Is patient wearing removable dental appliances?........ Yes No

Women

17. Is patient pregnant?........ Yes No

18. Is patient nursing? .... Yes No

19. Is patient taking birth control pills?........ Yes No

20. Is there any other medical (health) information you would like us to know? If yes, please explain ____________________ Yes No

The medical information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in my health and of recent visits to my physician at my next visit. In addition, I authorize Dr. Jack to perform a complete orthodontic examination.

Date ____________________ Signature ____

DENTAL HISTORY
GENERAL DENTAL INFORMATION

1. When was your last dental visit? ______________________________
2. How frequently do you visit your dentist? ______________________________
3. The name and address of my dentist is: ______________________________
4. When was you last full mouth or panoramic series of x-rays? ______________________________
5. Are you having any dental problems now? .... Yes No
   If yes, please specify ______________________________
   ____
6. I would describe my temperament as: ______________________________
7. My hobbies or sports interests are: ______________________________
8. Do you anticipate a move or transfer in the near future? .... Yes No
   If yes, please explain ______________________________
9. Are your teeth discolored? .... Yes No
10. Have you ever been in an auto accident? .... Yes No
    If yes, please explain ______________________________
    ____
11. Have you ever had an injury to your head, face, or neck? .... Yes No
    If yes, please explain ______________________________
12. Have you ever had teeth removed? .... Yes No
13. Have your wisdom teeth been removed? .... Yes No
    If yes, when and by whom? ______________________________
14. What is your main reason for seeking orthodontic treatment? ______________________________
    ____
15. Please specify any other reasons you have for seeking orthodontic treatment? ______________________________
    ____
    ____

ORTHODONTIC INFORMATION

1. Have you ever had orthodontic treatment (braces)? .... Yes No
   If yes, when and by whom ______________________________
2. Have you ever had an orthodontic examination, evaluation, conference or consultation? .... Yes No
   If yes, when and by whom ______________________________
3. Have you ever had orthodontic records, such as x-rays, study models or photographs? .... Yes No
   If yes, when and by whom ______________________________

PERIODONTAL (GUM) INFORMATION

1. Do you feel your gingiva (gums) are healthy? .... Yes No
   If no, please explain ______________________________
2. Do your gums bleed when brushing? .... Yes No
3. Have your gums ever bled when brushing? .... Yes No
4. Do you regularly use dental floss or tape? .... Yes No
   If yes, since when? ______________________________
5. Have you ever been told that you have gum disease? .... Yes No
   If yes, when and by whom? ______________________________
6. Have you ever been advised to have periodontal (gum) treatment? .... Yes No
7. Have you ever had a periodontal examination? .... Yes No
   If yes, when and by whom? ______________________________
8. Have you ever had periodontal (gum) treatment? .... Yes No
   If yes, when and by whom ______________________________

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

1. Do you feel your jaw joint is healthy? .... Yes No
If no, please explain ____________________

2. Does your jaw joints(s) click, crack, pop, grate or make any other sound(s)? .... Yes No
If yes, please explain ____________________

3. Has your jaw joint(s) ever made any of the above or other sounds? .... Yes No
If yes, please explain ____________________

4. Do you grind your teeth? .... Yes No

5. Do you clench your teeth? .... Yes No

6. Do you ever have or have you ever had jaw soreness, jaw pain, muscle soreness (jaw area) neck soreness? .... Yes No
If yes, please explain ____________________

7. Do you now or have you previously experienced aches or pains in the following areas:

a. From of the head.. Yes No
b. Over the eyes.. Yes No
c. Sinus area.. Yes No
d. Temple area.. Yes No
e. Cheeks or side of the face .... Yes No
f. Top of the head.. Yes No
g. Back of the head .... Yes No
h. Back of the neck.. Yes No
i. Side of the neck .... Yes No
j. Tongue or under the tongue.. Yes No
k. Front of the neck .... Yes No
l. Shoulders.. .... Yes No
m. Upper back.. Yes No
n. Lower back.. Yes No
o. Other pain, please describe .... Yes No

For the above problems, what circumstances seem to cause the problem(s). make it worse or make it better?

a) ____________________
b) ____________________
c) ____________________

8. Has your jaw ever “locked” open or closed? .... Yes No
If yes, please explain ____________________

9. Have you ever been told that you have a TMJ or “Jaw Joint” problem? .... Yes No
If yes, when and by whom ____________________

10. Have you ever had treatment for a TMJ “Jaw Joint” Problem? .... Yes No
If yes, when and by whom ____________________

The dental information provided is complete and correct to the best of my knowledge.
I agree to inform this office of any change(s) in my dental health and of recent visits to my dentist at my next visit.

Date ________________ Signature ____________________