Dr. Kresimir P Lackovic
DMD, MSc, Cert Ortho, FRCD(C), Dip ABO
Specialist in Orthodontics and Dentofacial Orthopaedics

Medical Dental History Form

Date____________

Last name ______________________________ First name ____________________________ Middle initial _______________

Preferred Name ___________________ Birthdate ______________ Sex: Male ☐ Female ☐

Home address ____________________________________ City ____________________ Prov _______ Postal code _____________

Home phone (______)_____________ Cell phone (______)________________ Work phone (______)_______________________

E-mail address____

DENTAL INSURANCE

Primary policy holder's full name ____ Birthdate ___________________

Relationship to patient ______________Address and phone (if not listed above) ____

Employer ____ Address ____

Insurance company ____________________________________ Group # _____________ ID# ___________________________

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

Primary policy holder's full name ____ Birthdate ___________________

Relationship to patient ______________Address and phone (if not listed above) ____

Employer ____ Address ____

Insurance company ____________________________________ Group # _____________ ID# ___________________________

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

DENTIST *(If you currently do not have a family dentist, please check the box ☐)*

Dentist ____________________________ Address ____

Last seen _______________________ Reason ____

PHYSICIAN

Physician ____________________________ Address ____

Last seen _______________________ Reason _______________________ Most recent physical exam _________________________

GENERAL INFORMATION

What concerns you about your teeth/smile? ____

How do you feel about orthodontic treatment? ____

Who suggested you might need orthodontic treatment? ____

Why did you select our office? ____

Describe any previous orthodontic treatment or consultations ____

Have any other family members been treated in this office? Please name them. ______________________________________

Who is financially responsible for this account? ____

What are your main expectations? (Please check **one**) ☐ Excellent results? ☐ Efficient results? ☐ Affordable pricing?

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Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. ***For the following questions mark yes, no, or don't know/understand (dk/u).***

MEDICAL HISTORY

Now or in the past, have you had:

- ▢**yes** ▢**no** ▢**dk/u** Birth defects or hereditary problems?
- ▢**yes** ▢**no** ▢**dk/u** Bone fractures, or major injuries?
- ▢**yes** ▢**no** ▢**dk/u** Any injuries to face, head, neck?
- ▢**yes** ▢**no** ▢**dk/u** Arthritis or joint problems?
- ▢**yes** ▢**no** ▢**dk/u** Endocrine or thyroid problems?
- ▢**yes** ▢**no** ▢**dk/u** Diabetes or low sugar?
- ▢**yes** ▢**no** ▢**dk/u** Kidney problems?
- ▢**yes** ▢**no** ▢**dk/u** Cancer, tumor, radiation treatment or chemotherapy?
- ▢**yes** ▢**no** ▢**dk/u** Immune system problems?
- ▢**yes** ▢**no** ▢**dk/u** History of osteoporosis?
- ▢**yes** ▢**no** ▢**dk/u** Gonorrhea, syphilis, herpes, STD's?
- ▢**yes** ▢**no** ▢**dk/u** AIDS or HIV positive?
- ▢**yes** ▢**no** ▢**dk/u** Hepatitis, jaundice or other liver problem?
- ▢**yes** ▢**no** ▢**dk/u** Polio, mononucleosis, tuberculosis, pneumonia?
- ▢**yes** ▢**no** ▢**dk/u** Seizures, fainting spells, neurologic problem?
- ▢**yes** ▢**no** ▢**dk/u** Mental health disturbance or depression?
- ▢**yes** ▢**no** ▢**dk/u** Vision, hearing, or speech problems?
- ▢**yes** ▢**no** ▢**dk/u** History of eating disorder (anorexia, bulimia)?
- ▢**yes** ▢**no** ▢**dk/u** High or low blood pressure?
- ▢**yes** ▢**no** ▢**dk/u** Excessive bleeding or bruising, anemia?
- ▢**yes** ▢**no** ▢**dk/u** Chest pain, short of breath, tire easily, swollen ankles?
- ▢**yes** ▢**no** ▢**dk/u** Heart defects, heart murmur, rheumatic heart disease?
- ▢**yes** ▢**no** ▢**dk/u** Angina, arteriosclerosis, stroke or heart attack?
- ▢**yes** ▢**no** ▢**dk/u** Skin disorder (other than common acne)?
- ▢**yes** ▢**no** ▢**dk/u** Do you eat a well-balanced diet?
- ▢**yes** ▢**no** ▢**dk/u** Frequent headaches or migraines?
- ▢**yes** ▢**no** ▢**dk/u** Frequent ear infections, colds, throat infections?
- ▢**yes** ▢**no** ▢**dk/u** Asthma, sinus problems, hayfever?
- ▢**yes** ▢**no** ▢**dk/u** Tonsil or adenoid condition?
- ▢**yes** ▢**no** ▢**dk/u** Do you frequently breathe through your mouth?

▢**yes** ▢**no** ▢**dk/u** Have you ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?

▢**yes** ▢**no** ▢**dk/u** **Have you ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone Disorders?**

Have you had allergies or reactions to any of the following:

- ▢**yes** ▢**no** ▢**dk/u** Local anesthetics (Novocain, lidocaine, xylocain)
- ▢**yes** ▢**no** ▢**dk/u** Latex (gloves, balloons)
- ▢**yes** ▢**no** ▢**dk/u** Aspirin
- ▢**yes** ▢**no** ▢**dk/u** Ibuprofen (Motrin, Advil)
- ▢**yes** ▢**no** ▢**dk/u** Penicillin
- ▢**yes** ▢**no** ▢**dk/u** Other antibiotics
- ▢**yes** ▢**no** ▢**dk/u** Metal (jewelry, clothing snaps)
- ▢**yes** ▢**no** ▢**dk/u** Acrylics
- ▢**yes** ▢**no** ▢**dk/u** Plant pollens
- ▢**yes** ▢**no** ▢**dk/u** Animals
- ▢**yes** ▢**no** ▢**dk/u** Foods
- ▢**yes** ▢**no** ▢**dk/u** Other substances ______________________

DENTAL HISTORY

- ▢**yes** ▢**no** ▢**dk/u** Brush teeth daily?
- ▢**yes** ▢**no** ▢**dk/u** Floss teeth daily?
- ▢**yes** ▢**no** ▢**dk/u** Erupting teeth very early or very late?
- ▢**yes** ▢**no** ▢**dk/u** Baby teeth removed that were not loose?
- ▢**yes** ▢**no** ▢**dk/u** Permanent or extra teeth removed?
- ▢**yes** ▢**no** ▢**dk/u** Supernumerary (extra) or congenitally missing teeth?
- ▢**yes** ▢**no** ▢**dk/u** Chipped or injured primary or permanent teeth?
- ▢**yes** ▢**no** ▢**dk/u** Any sensitive or sore teeth?
- ▢**yes** ▢**no** ▢**dk/u** Jaw fractures, cysts, infections?
- ▢**yes** ▢**no** ▢**dk/u** Any teeth treated with root canals or pulpotomies?
- ▢**yes** ▢**no** ▢**dk/u** "Gum boils," frequent canker sores or cold sores?
- ▢**yes** ▢**no** ▢**dk/u** History of speech problems or speech therapy?
- ▢**yes** ▢**no** ▢**dk/u** Difficulty breathing through nose?
- ▢**yes** ▢**no** ▢**dk/u** Mouth breathing habit or snoring at night?
- ▢**yes** ▢**no** ▢**dk/u** History of speech problems?
- ▢**yes** ▢**no** ▢**dk/u** Frequent oral habits (sucking finger, thumb, etc.)?
- ▢**yes** ▢**no** ▢**dk/u** Teeth causing irritation to lip, cheek or gums?
- ▢**yes** ▢**no** ▢**dk/u** Tooth grinding or clenching?
- ▢**yes** ▢**no** ▢**dk/u** Clicking, locking in jaw joints?
- ▢**yes** ▢**no** ▢**dk/u** Soreness in jaw muscles or face muscles?
- ▢**yes** ▢**no** ▢**dk/u** Been treated for "TMJ" or "TMD" problems?
- ▢**yes** ▢**no** ▢**dk/u** Any broken or missing fillings?
- ▢**yes** ▢**no** ▢**dk/u** Any serious problems with previous dental visits?
- ▢**yes** ▢**no** ▢**dk/u** Been diagnosed with gum disease?

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FAMILY MEDICAL HISTORY

▢**yes** ▢**no** ▢**dk/u** Bleeding disorders
▢**yes** ▢**no** ▢**dk/u** Diabetes
▢**yes** ▢**no** ▢**dk/u** Arthritis
▢**yes** ▢**no** ▢**dk/u** Sever allergies
▢**yes** ▢**no** ▢**dk/u** Unusual dental problems
▢**yes** ▢**no** ▢**dk/u** Jaw size imbalance
▢**yes** ▢**no** ▢**dk/u** Other family medical conditions

PATIENT HEALTH INFORMATION

Do you think that any of your activities affect your face, teeth or jaws? How? ____

List any medication, nutritional supplements, herbal medication or non-prescription medicines, including fluoride supplements that you take.

Medication ____ Taken for ____

Medication ____ Taken for ____

Medication ____ Taken for ____

Do you currently have (or ever had) a substance abuse problem? ____

Do you chew or smoke tobacco? ____

Have you noticed any unusual changes in your face or jaws? ____

Any other physical problems? ____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature ____ Date ____________________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature ____ Date ____________________________