COWAN ORTHODONTICS
R. GLEN COWAN, JR., D.M.D., M.S.

MEDICAL HISTORY FORM

PATIENT INFORMATION

Patient's Name _____ (Last / First / Name Prefer to be called / Middle Int.)

Home/Cell Phone _____ Birthdate _____ Gender _____

Address _____ (Street / City / State / Zip)

If Patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____ General Dentist _____

Other family members previously in our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____ (Last / First / Middle / Marital Status)

Residence _____ (Street / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

How long at this address _____ Phone _____ Work Phone _____

Cell Phone Carrier _____

Previous Address (if less than 3 years) _____

Email _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last / First / Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Email _____ Birthdate _____ Relationship to Patient _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Contract # _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If yes: _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Contract # _____

Insurance Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone Number _____

I authorize Dr. Cowan to release my records to other dental/medical professionals as needed during observations, treatment, and retention.

Signature (Parent's signature in minor) _____ Date _____

Updates (date and initial) _____

MEDICAL HISTORY

Are you in good health? _____ yes _____ no Explain _____

Any major or unusual illnesses? _____ yes _____ no Explain _____

Currently being treated by a physician? _____ yes _____ no Explain _____

Currently taking medications? _____ yes _____ no Explain _____

Allergies? _____ yes _____ no Explain _____

Drug Sensitivity? _____ yes _____ no Explain _____

Latex Allergy? _____ yes _____ no

Metal Allergy? _____ yes _____ no

Please check if you have any of the following:

YES	NO		YES	NO		YES	NO	
_____	_____	Anemia	_____	_____	Heart Problems	_____	_____	HIV
_____	_____	Blood Disease	_____	_____	Tuberculosis	_____	_____	Tonsillitis
_____	_____	Prolonged Bleeding	_____	_____	Diabetes	_____	_____	Tonsils Removed: Age _____
_____	_____	Jaundice	_____	_____	Endocrine Problems	_____	_____	Adenoids Removed: Age _____
_____	_____	Rheumatic Fever	_____	_____	Bone Disorders	_____	_____	Asthma
_____	_____	Scarlet Fever	_____	_____	Epilepsy	_____	_____	Mouthbreathing
_____	_____	Hepatitis	_____	_____	Fever Blisters		_____	While Awake
_____	_____	Frequent Colds/Flu	_____	_____	ADD/ADHD		_____	While Asleep

DENTAL HISTORY

YES	NO	
_____	_____	Have you ever had any severe head or face injuries? Explain _____
_____	_____	History of thumb sucking or finger sucking? Stopped? _____ When? _____
_____	_____	Do you play any musical (wind) instruments? What? _____
_____	_____	Have you consulted an orthodontist previously? _____
_____	_____	Have any family members had orthodontic treatment? _____
_____	_____	Do you normally take antibiotics prior to dental cleaning? _____
_____	_____	Previous periodontal (gum) treatment? When? _____ Where? _____
_____	_____	When was your last dental cleaning? _____

Please check if there is a history of:

_____ Clenching/Grinding Teeth _____ Headaches (more than normal) _____ Jaw Joint Popping/Clicking

_____ Jaw Joint Soreness _____ Ringing In the Ears _____ Muscular Soreness around Head and Neck

What do you think is your orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

Is there any other information that may be helpful? _____

Additional information:

_____

_____

_____