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. # _____

Insured Address _____ Insured Date of Birth _____

Insurance Company _____ Group # _____ Contract # _____

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

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

Insured Address _____ Insured Date of Birth _____

Insurance Company _____ Group # _____ Contract # _____

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:

_____

_____

_____