

◇ Donald J. Turner, D.D.S. ◇

Orthodontics, T.M.J.
Facial Orthopedics

2424 Enterprise Road
Suite B
Clearwater, FL 33763
Phone: (727) 797-5460

Welcome To Our Office

To better understand your dental health needs and your feelings toward orthodontics, we'd like you to help us become better acquainted. If you are registering in our office please tell us when you have completed the questions. Thank you!

Your Name [Mr. / Mrs. / Dr. / Miss] _____ Birthdate _____
Last First Middle Initial Month Day Year

Home Address _____ Home Phone _____
Street Apt # City ZIP

Employed By _____ Business Phone _____
(Business name or occupation – give address if used for correspondence)

Spouse's Name [Mr. / Mrs. / Dr.] _____ Business Phone _____
Last First Middle Initial

Spouse Employed By _____
(Business name or occupation – give address if used for correspondence)

Your Dentist(s) _____ Your Physician(s) _____

Whom may we thank for referring you? _____
(Dentists, relatives, friends who helped you decide to choose us)

Preferred Appointments: _____
Day(s) Time(s)

MEDICAL HISTORY

	Yes	No	
Are you in good health? _____	<input type="checkbox"/>	<input type="checkbox"/>	Date of last complete exam? _____
Are you being treated by a physician now? _____	<input type="checkbox"/>	<input type="checkbox"/>	For what? _____
Are you taking any medicines now? If yes, please list _____	<input type="checkbox"/>	<input type="checkbox"/>	Reason: _____
Are you dieting or taking dietary supplements? _____	<input type="checkbox"/>	<input type="checkbox"/>	Reason: _____
Have you been hospitalized in the last five (5) years? _____	<input type="checkbox"/>	<input type="checkbox"/>	Due Date: _____
Women, are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever been treated by a physician for:

	Yes	No		Yes	No	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung disorders	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>
High / low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____	Acquired Immune Defic. (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Chronic nasal blockage	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach ulcers/disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
A blood transfusion in past three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Allergic to: <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin			_____			
<input type="checkbox"/> Codeine <input type="checkbox"/> Local anesthetic			_____			

Is there any other information concerning your health of which the doctor should be aware?

PLEASE CONTINUE ON NEXT PAGE

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DENTAL HISTORY

Have you ever had:

	Yes	No		Yes	No
An injury to face or teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you use dental floss daily?	<input type="checkbox"/>	<input type="checkbox"/>
A tooth clenching or grinding habit?	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
A speech or gagging problem?.....	<input type="checkbox"/>	<input type="checkbox"/>	Does your food wedge between certain teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any clicking or pain when opening your jaw?.....	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive (hot, cold, sweets)?	<input type="checkbox"/>	<input type="checkbox"/>
Recent pain around ears or side of face?	<input type="checkbox"/>	<input type="checkbox"/>	Have your teeth shifted, tipped, loosened?	<input type="checkbox"/>	<input type="checkbox"/>
Soreness in muscles of your face?	<input type="checkbox"/>	<input type="checkbox"/>	Do you eat sugars (often, moderately, seldom)	<input type="checkbox"/>	<input type="checkbox"/>
Any biting habits (cheek, nails, pens, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever seen an orthodontist?	<input type="checkbox"/>	<input type="checkbox"/>
Recent discomfort from your teeth or gums?.....	<input type="checkbox"/>	<input type="checkbox"/>	When: _____ Whom: _____		

Date: _____ Signature: _____

THANK YOU

Do you have orthodontic insurance? Yes _____ No _____ Company Name _____
Group Number: _____ Social Security Number: _____

FURTHER INSIGHTS

Please tell us what you feel is your present orthodontic problem _____

How might orthodontics help resolve this problem? _____

How long did you consider orthodontics before coming today? _____

What led you to finally decide to have an orthodontic check up? _____

Please tell us what you do on a *regular* basis to maintain your health _____

Please list some of our patients you know _____

What do you like to do when your time is your own? Indicate the activities and interests you or your spouse/family enjoy participating in on a regular basis _____

Please describe your nature or character (i.e.: quiet, outgoing, self-conscious, leader, one of the group, etc.) _____

Thank You!

Do you want to make the doctor aware of any other concerns? Please feel free to discuss any feelings of hesitation about beginning orthodontics, any special needs, or any personal concerns.

