ORTHODONTIC MEDICAL HISTORY

BRIDGE CITY BRACES
DR. JOFFRE MARTIN, DMD

Please indicate below how you would like to be reminded of your appointments:

○ Text ○ E-mail ◉ Both

Today's Date: _____

Parent/Guardian's Name: _____

Patient's Name: _____

Patient's DOB: _____

Address: _____ Zip Code: _____

Cell Phone #: _____

Carrier (Ex: Verizon/ATT): _____

Emergency Contact: _____

E-mail: _____

Allergies: _____

Chief Orthodontic Concern: _____

Referred By/Patient's Dentist: _____

Previous Orthodontic Treatment: _____

HISTORY OF:

Heart Condition: ○Y ◉N Epilepsy: ◉Y ○N Asthma: ○Y ◉N Bleeding Disorder: ○Y ◉N

Heart Murmur: ○Y ◉N HIV: ○Y ◉N Diabetes: ○Y ◉N

Delay in Physical/Mental Development: _____

ORAL HABITS:

Thumb Sucking: ○Y ◉N Tongue Thrusting: ○Y ◉N Nail Biting: ○Y ○N Teeth Grinding: ○Y ○N

Smoking: ○Y ○N Mouth Breathing: ○Y ○N Speech Problems: ○Y ○N Clicking/Pan in Jaw (TMJ): ○Y ○N

DENTAL INSURANCE:

Subscriber: _____ Subscribers SS#: _____

Insurance Company: _____ Group #: _____

Subscribers DOB: _____ Policy #: _____