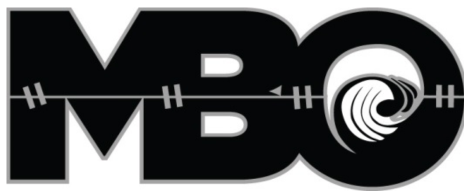

Monterey Bay
ORTHODONTICS
GARRETT CRISWELL DDS MS

Personal History
Patient's First Name______________________________
Patient's Last Name______________________________
S.S.N.__________________ Sex: Male___ Female__
Salutation: Mr. Mrs. Ms. Miss Dr.
Date of Birth:______________________ Age:________
Email Address___________________________________
Phone:________________________ Work:___________
Home Address:_________________________________
City________________ Zip________________
What is your Orthodontic Concern?_________________

Medical History
Are you under a Dr.'s Care?____________________
If yes, why?________________________________
Are you taking any Medications/Drugs?_________
If yes, why?________________________________
Do you have or have you had:
1. Reaction to Meds or drugs?_________________
2. Allergies?________________________________
If yes, to what?______________________________
3. Are you currently or have you in the past taken bisphosphonate for Osteoporosis?____________

Whom may we thank for referring you:____
General Dentist:__________________________
Family Physician_________________________
Emergency Contact _______________________
Phone _________________________________
Employer_________________ Phone__________
Name of your Dental Insurance _______________
____
ID # ____________________________________
S.S.N.__________________ DOB_____________
Insurance Phone #___________________________

Spouse ________________________________
Address__________________________ Zip_______
Phone________________________ DOB_________
Employer_________________________________
Name of spouses Dental Insurance: _____________
________________ ID # _____________________
S.S.N._____________ Ins. Phone #_____________

	Y	N		Y	N		Y	N
Blood Disorders			Epilepsy			Whooping cough		
Hemophilia			Scarlet fever			Drug addiction		
Blood transfusions			Rheumatic Fever			Breathing issues		
High blood pressure			Emphysema			Fainting Spells		
Anemia			Arthritis			Swallowing issues		
Heart Condition			Pneumonia			Speech issues		
Heart Murmur			Tuberculosis			Bleeding problems		
Congenital Heart Issues			Rheumatism			Nervousness		
Heart Surgery			Mumps			Currently Pregnant		
Angina			Thyroid disease			Asthma		
Aids or HIV			Liver disease			Sinus Problems		
Diabetes			Kidney problems			Frequent colds		
Hepatitis			contacts			Headaches		
Cancer			Endocrine issues			Cold Sores		

DENTAL HISTORY
Are you serious about wanting your teeth straightened?______________________
Do you visit your dentist regularly?_____________________________________
Have you had any serious injury to your face or jaw?_______________________
Any discomfort opening/closing your mouth?_______________________________
Any clicking or popping or grinding when you open/close?__________________
Do you grind or clinch your teeth?______________________________________
Have you had a previous orthodontic consultation?__________________________
Have you ever had the following treatment (s):?
Orthodontic straightening? ____________As a Child? _________ Adult?_________
Periodontal Treatment (gum disease)? _______________ When?_______________
Extractions? ________When? _________________ Why?___________________
Mouth guard or splint (plastic device between your teeth)?____________________
Treatment or Surgery to change your jaw or bite?____________________________

To the best of my knowledge, all of these answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor at the next appointment without fail.

Signature of patient,
Parent or Guardian __________________________________ Date__________ Dr's Signature_____________________