Monterey Bay ORTHODONTICS
GARRETT CRISWELL DDS MS

Personal History

Patient's First Name_____
Patient's Last Name_____
Sex: Male_____ Female_____
Date of Birth:_____ Age:_____
Email Address_____
Phone:_____ Wk:_____
Home Address:_____
City_____ Zip_____
General Dentist:_____

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?_____
Name and ages of Siblings:_____
Responsible Party(s)_____
Emergency Contact Name & #_____
Family Physician_____
Whom does patient live with:_____
School_____ Grade_____

Father's Name_____
Address_____ Zip_____
Phone_____ DOB_____
Employer_____ Phone#_____
Name of Dental Insurance_____
S.S.N._____ ID #_____

Mother's Name_____
Address_____ Zip_____
Phone_____ DOB_____
Employer_____Phone_____
Name of Dental Insurance_____
S.S.N._____ID #_____

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?_____
Did you suck your thumb/pacifier/fingers?_____
Have you had a previous orthodontic consultation?_____

Have you ever had the following treatment(s)?:
Orthodontic straightening? _____
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?_____

	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		

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_____