48. Do you have asthma? YES NO
49. Do you have hay fever or other environmental allergies (to food, cat's fur, dust, etc.) ? YES NO
50. Do you have hives or skin rash? YES NO
51. Do you have an allergy to latex or balloons? YES NO
52. Do you have an allergy to nickel or other metals? YES NO
53. Do you have numbness in any part of your body? YES NO
54. Has any part of your body ever been paralyzed? YES NO
55. Do you ever have fits, convulsions or epilepsy? YES NO
56. Do you have a tendency to faint? YES NO
57. Do you have frequent, severe headaches? YES NO
58. Do you have sinus problems? YES NO
59. Have you ever been diagnosed with or treated for sleep apnea? YES NO
60. Do you have a snoring problem that you are aware of? YES NO
61. Do you consider yourself to be a nervous person? YES NO
62. Do you often feel unhappy and depressed? YES NO
63. Are you easily upset or irritated? YES NO
64. Do you have any behavior disorders or mental health problems? YES NO
65. Women -- Are you pregnant at this time? YES NO
66. Women -- Are you in or have you passed the menopause (change of life)? YES NO
67. Women -- Have you had a hysterectomy or ovariectomy? YES NO
68. Have you ever or are you now taking a drug of the class Bisphosphonate or Diphosphonates for osteoporosis? Examples: Fosamax, Boniva, Actonel, Zometa or Reclast YES NO
69. Is there any other information about your dental or medical health history you feel we should know about? YES NO

_____

_____

I grant permission for Evans Orthodontics to release pertinent information to dental offices.

Signature of Patient _____ Date_____

I have reviewed this history. Dr. Signature _____Date_____

Updates (date and initial) _____

FORM# PH1

EVANS ORTHODONTICS, P.C.
600 Dakota Dr.
Rapid City, SD 57702
605 342-7777
www.evansortho.com

1. About You

Appointment Date _____/_____/_____

Name _____ (Last First Middle)

I prefer to be called _____

Home Address _____

_____

Email Address _____

Birth date _____/_____/_____ Age _____

SS # _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home # _____ Cell # _____

Work # _____ Ext _____

Employer _____

Occupation _____

Where and when are the best times to reach you?

_____

Whom may we thank for referring you?

_____

Is there a staff member at Evans Orthodontics who is primarily responsible for you choosing our office? YES NO

If so, who? _____

2. Spouse Information

His/Her Name _____ (Last First Middle)

Employer _____

Occupation _____

Work # _____ Cell # _____

SS # _____

Birth date _____/_____/_____

3. Emergency Contact

Name of nearest relative or friend not living with you

_____ (Last First Middle)

Relationship _____

Cell # _____ Home # _____

4. Person Responsible for Financial/Account

Name _____ (Last First Middle)

Relationship to patient _____

Mailing Address _____

_____

Years at this address _____

SS # _____ DOB _____

Home # _____

Work # _____ Cell # _____

Employer _____

Occupation _____ Years Employed ____

I authorize a credit report _____ (Signature)

5. Orthodontic Insurance

Primary

Insured Name _____

SS or ID # _____ DOB _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Phone # _____

Secondary

Insured Name _____

SS or ID # _____ DOB _____

Insured's Employer _____

Insurance Co. Name _____

Insurance Co. Phone # _____

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records only. Naturally they will be considered confidential and will become part of your permanent dental record.

Height_____Weight_____

Physician's Name_____

Dentist's Name_____Date of Last Visit_____

What is your estimation of your general health? (circle one) Good, Fair, Poor

What is your main reason for seeking orthodontic care?_____

_____

If any of the following are answered yes; please give a brief explanation.

1. Has Dr. Evans treated others in your family? YES NO
2. Has an orthodontist been consulted previously? YES NO
3. Have you ever experienced any unfavorable reactions from previous dental or medical care? YES NO

   Please explain:_____
4. Have you had a toothache recently? YES NO
5. Is there any history of thumb-sucking, finger-sucking, lip biting or nail biting? YES NO
6. Have you visited a dentist within the past year? YES NO
7. Do you think your teeth are affecting your general health in any way? YES NO
8. Are you worried about receiving orthodontic treatment? YES NO
9. Do you have difficulty chewing your food? YES NO
10. Do you have any cheek biting problems? YES NO
11. Do you have sensitive teeth? YES NO
12. Do you have bleeding gums or periodontal "gum" disease? YES NO
13. Have you ever had sores in the mouth or on the lips that are slow to heal? YES NO
14. Do you have difficulty in opening your mouth widely? YES NO
15. Do you have any speech problems? YES NO
16. Do you grind your teeth at night? YES NO
17. Have you ever chipped a tooth or had a serious blow to the teeth? YES NO
18. Have you ever had any injury to your face or jaws? YES NO
19. Have you ever been treated for "TMJ"? (jaw joint problems) YES NO
20. Do your jaw joints ever click or pop? YES NO
21. Has your jaw ever "locked" open or closed? YES NO
22. Have you been examined by your physician within the last year? YES NO
23. Are you being treated for any condition by a physician now? YES NO

    What is the condition?_____
24. Have you been taking any medicines within the past year? YES NO

    Please list them here: _____
25. Have you ever been hospitalized or seriously ill? YES NO

    If yes, what was the problem? _____
26. Have you ever had surgery (an operation)? YES NO

    If yes, what was the surgery? _____
27. Are you frequently exhausted, fatigued or ill? YES NO
28. Has there been any change in your general health in the past year? YES NO
29. Have you lost or gained weight in recent months? YES NO
30. Have you ever had a blood transfusion? YES NO
31. Have you ever had X-ray or surgery treatment for a tumor, growth, or other conditions anywhere including your head, mouth or on your lips? YES NO
32. Have you ever had any kind of the following diseases or conditions:

Diabetes (sugar disease)	YES	NO	Hepatitis or Jaundice (yellow skin & eyes)	YES	NO
Tuberculosis or Polio	YES	NO	Chicken Pox	YES	NO
Measles	YES	NO	Mumps	YES	NO
Sexually Transmitted Disease	YES	NO	Immune Disorder or HIV	YES	NO
Heart Attack or Stroke	YES	NO	Rheumatic Fever	YES	NO
Ulcers	YES	NO	Scarlet Fever	YES	NO
Epilepsy	YES	NO	Glaucoma	YES	NO

33. Have you ever had painful or swollen joints? YES NO
34. Do you currently have a heart murmur or did you ever take the diet drug Phen-Fen? YES NO

    If yes, do you need antibiotic premedication before routine dental work? YES NO
35. Do you have or have you ever had any heart trouble or chest pain on exertion? YES NO
36. Do you have high blood pressure? YES NO
37. Do you bruise easily or bleed for a long time when you cut yourself? YES NO
38. Do you have any blood disorder such as anemia (thin blood)? YES NO
39. Do your ankles ever swell? YES NO
40. Do you have a persistent cough? YES NO
41. Do you have to urinate frequently, either during the day or night? YES NO
42. Are you thirsty much of the time? YES NO
43. Has a doctor ever said you had kidney or bladder disease or infection? YES NO
44. Has a doctor ever said you had liver disease? YES NO
45. Have you ever experienced an unusual reaction to any of the following drugs:

Penicillin	YES	NO	Iodine	YES	NO
Augmentin	YES	NO	Sulfa Drugs	YES	NO
Ceclor	YES	NO	Banthine or Atropine	YES	NO
Erythromycin	YES	NO	Other Medicine_____	YES	NO

46. Have you ever experienced an unusual reaction to a dental anesthetic? ("Novocaine injection") YES NO