Laura L. Willhoite, D.D.S.

Specialist in Orthodontics

Dental and Medical History for_____

Name of General Dentist_____
Date of last dental check-up _____/_____/_____

Have you ever been evaluated for orthodontic treatment? YES / NO
Have there been any injuries to the face, mouth, teeth or chin? YES / NO

I yes, explain_____

Are you under the care of a physician? YES / NO

If yes, state Doctor's Name_____

Please list all drugs you are currently taking and for what purpose _____
_____

Please list all drugs you are allergic to _____
_____

Do you have a heart condition requiring pre-medication with antibiotics prior to dental work?
YES / NO _____

Are you allergic to nickel? YES / NO Are you allergic to latex? YES / NO

Have you exhibited any of the following habits in the past (mark with X) or still exhibit these habits now (mark with O)?

Mouth Breathing	_____	Thumb Sucking	_____	Finger Sucking	_____
Grinding Teeth	_____	Lip Biting	_____	Thrusting	_____
Clenching Teeth	_____	Nail Biting	_____		

Have you had any of the following medical problems:

Allergies	_____	Hepatitis / Jaundice	_____	HIV / AIDS	_____
Asthma	_____	Heart Trouble	_____	Other	_____
Sinus Infection	_____	Glandular Disorder	_____		
Diabetes	_____	Rheumatic Fever	_____		

I state that the information given above is correct. I understand that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature_____Date_____/_____/_____