Welcome!

METZ ORTHODONTICS

John J. Metz, DMD, MS

Medical & Dental Health History Form

Patient Name _____ Date of Birth _____

Home Phone Number _____ Cell Number _____ Initial here if we may send appointment reminders via text message _____

Address _____

City _____ State _____ Zip _____

Email _____

Occupation _____

Emergency Contact (name & phone number) _____

_____

Health History: Do you have, or have you ever had, any of the following conditions:

Yes	No		Yes	No	
☐	☐	Food/Drug Allergies	☐	☐	High/ Low Blood Pressure
☐	☐	Anemia	☐	☐	Infectious Diseases: (Circle)
☐	☐	Asthma			Herpes HIV Tuberculosis Hepatitis
☐	☐	Artificial Joints/Valves	☐	☐	Jaundice
☐	☐	Bleeding Problems	☐	☐	Kidney Disease
☐	☐	Cancer / Chemotherapy	☐	☐	Liver Disease
☐	☐	Cleft Lip & Palate	☐	☐	Pregnant/Nursing
☐	☐	Delayed Speech Development	☐	☐	Psychiatric Problems
☐	☐	Difficulty Breathing	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Seizures
☐	☐	Emotional Disturbances	☐	☐	Sickle Cell Anemia
☐	☐	Fainting Spells	☐	☐	Other _____
☐	☐	Hearing Loss/Impairment			_____
☐	☐	Heart Condition			_____

CONTINUED ON BACK

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Are you currently seeing a physician? _____ Why? _____

Physician's Name: _____

Are you taking any medications? ☐ Yes ☐ No If yes, please list:

1. _____ 3. _____

2. _____ 4. _____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please explain:

_____

Dental Health:

Yes	No	
☐	☐	Have you ever had a toothache?
☐	☐	Have you ever received a blow or injury to your teeth?
☐	☐	Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ)?
☐	☐	Does brushing cause your gums to bleed?
☐	☐	Ever had any unhappy dental experience?

Why are you here today? (Main orthodontic concern) _____

_____

When was your last dental appointment? _____

How have you reacted to past medical or dental procedures?

☐ Very good ☐ Moderately ☐ Moderately poor ☐ Very poor

Do you think there is anything wrong with your teeth? ☐ Yes ☐ No If yes, please explain:

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature _____ Date _____