Dr. Neeraj Pershad
Orthodontist

NIAGARA PENINSULA orthodontics

Adult Patient History Form

Name _____ Age_____ Sex____ DOB _____ Occupation _____

Home Address_____City_____ Postal Code_____

Home Tel_____ Cell Tel_____ Email_____

Business Address _____Work Tel_____

Whom may we thank for referring you to our office? _____

Do you have Orthodontic Insurance? ☐ Yes ☐ No Name of Ins company_____

MEDICAL HISTORY: Physician:_____Phone:_____

Have you had or been treated for any of the following?

Rheumatic fever ☐Y ☐N	Herpes ☐Y ☐N	Prolonged Bleeding ☐Y ☐N	Asthma ☐Y ☐N
Heart Murmur ☐Y ☐N	Tuberculosis ☐Y ☐N	Epilepsy ☐Y ☐N	Swollen glands ☐Y ☐N
Mitral Valve Prolapse ☐Y ☐N	HIV/ AIDS ☐Y ☐N	Mental health problems ☐Y ☐N	Arthritis ☐Y ☐N
Heart Disease ☐Y ☐N	Hepatitis A, B or C ☐Y ☐N	Diabetes ☐Y ☐N	Allergies ☐Y ☐N
Artificial Heart Valve ☐Y ☐N	STD's ☐Y ☐N	Kidney disease ☐Y ☐N	Other:_____
Artificial Joints ☐Y ☐N	Blood disease ☐Y ☐N	Liver Disease ☐Y ☐N	_____

If you responded YES to any of the above, please give other significant information _____

_____

Are you under a physician's care at present? If yes, reason_____

Have you had any major illness and/ or operations ? _____

Are you allergic to any medications? (e.g.: aspirin, penicillin, etc.) If yes, what?_____

Please list any medications being taken_____

Do you have a tendency to colds? _____Sore Throats?_____ Ear Infections?_____

Have you the tonsils or adenoids been removed?_____

Women- are you pregnant? _____

Are there other children in the family? Names and ages_____

Please describe why you sought this consultation_____

_____

DENTAL HISTORY: Dentist:_____Date of last visit:_____

Yes No

- ☐ ☐ Do you require any dental work including cleanings, extractions or fillings?_____
- ☐ ☐ Have you had any injuries to your face, mouth or teeth? If yes, describe_____
- ☐ ☐ Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe_____
- ☐ ☐ Have you been informed of any missing or extra permanent teeth? Which ones?_____
- ☐ ☐ Have you ever had any surgery in the head and neck area? If yes, describe_____
- ☐ ☐ Have you ever sucked your thumb/finger. Until what age?_____
- ☐ ☐ Have you ever had an orthodontic exam? _____ Have you ever had orthodontic treatment?_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

Signature Date

_____ _____ Doctor

NOTES:_____

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