



# Tinsworth Orthodontics

*Creating a Bright Future... One Smile at a Time*

## OBSERVATION PATIENT CARE UPDATE

PLEASE REVIEW AND CORRECT ANY MISSING OR INACCURATE INFORMATION LISTED BELOW:

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred Office: \_\_\_\_\_ Patient's Social Security # \_\_\_\_\_

\*Birth Date: \_\_\_\_\_ Nickname: \_\_\_\_\_

\*Child's Home Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Home Phone: \_\_\_\_\_ Patient's Cell/Other: \_\_\_\_\_

Patient's Email: \_\_\_\_\_ Patients' School: \_\_\_\_\_  
(if appropriate)

Mother's Name: \_\_\_\_\_

Mother's Address if different than Child's:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mother's Home

Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Mother's \_\_\_\_\_ Length of \_\_\_\_\_

Employer: \_\_\_\_\_ Employment: \_\_\_\_\_

Mother's Work \_\_\_\_\_

Number: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Address if different than Child's:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Father's Home  
Number

\_\_\_\_\_

Cell Number:

\_\_\_\_\_

Length of

Father's Employer:

\_\_\_\_\_

Employment:

\_\_\_\_\_

Father's Work

Number:

\_\_\_\_\_

Email:

\_\_\_\_\_

\*Mother's Marital Status:

Married to father

Widowed

Divorced

Remarried to stepfather

Separated

Single

\*Father's Marital Status:

Married to mother

Widowed

Divorced

Remarried to stepmother

Separated

Single

### *Emergency Contact Information*

Name of the nearest relative  
not living with patient?

\_\_\_\_\_

Home Address:

Relationship to Patient:

\_\_\_\_\_

Home Number:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### *Patient Dental History*

Dentist:

\_\_\_\_\_

Date of Last Visit:

\_\_\_\_\_

### *Patient Medical History*

*Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.*

Physician:

\_\_\_\_\_

Medical Group:

\_\_\_\_\_

Date of Last Visit:

\_\_\_\_\_

Phone:

\_\_\_\_\_

Doctors Address:

\_\_\_\_\_

\_\_\_\_\_

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Does the patient have a history of any major illness?

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Any major operations?

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Has the patient ever been involved in a serious accident?

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Does the patient smoke or use tobacco in any form?  Yes  No

Has the patient ever taken any Diet Medications?  Yes  No

*Is the Patient taking any of the following medications?*

- |  |  |
|--|--|
| <input type="checkbox"/> Acetaminophen             | <input type="checkbox"/> Digitalis/Heart Medications |
| <input type="checkbox"/> Antibiotics               | <input type="checkbox"/> Insulin/Diabetes Drugs      |
| <input type="checkbox"/> Antihistamines            | <input type="checkbox"/> Nitroglycerin               |
| <input type="checkbox"/> Aspirin                   | <input type="checkbox"/> Recreational Drugs          |
| <input type="checkbox"/> Blood Thinners            | <input type="checkbox"/> Steroids/Cortisone          |
| <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> Thyroid Medications         |
| <input type="checkbox"/> Cold Remedies             | <input type="checkbox"/> Tranquilizers               |

*Has the patient taken or currently taking any Bone Deficiency Medications?*

- |  |  |
|--|--|
| <input type="checkbox"/> Alendronate (Fosamax) | <input type="checkbox"/> Pamidronate (Aredia)  |
| <input type="checkbox"/> Etidronate (Didronel) | <input type="checkbox"/> Risedronate (Actonel) |
| <input type="checkbox"/> Ibandronate (Boniva)  | <input type="checkbox"/> Zoledronate (Zometa)  |

Other?

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*Please check any of the following that you have had or currently have:  
(Note: Please do not assume something is not related to our best care for you. Please be complete.)*

- |  |   |
|--|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia  | <input type="checkbox"/> Bone disorders, bone fractures   |
| <input type="checkbox"/> Alcohol Abuse   | <input type="checkbox"/> Cancer, tumor, radiation treatment or chemotherapy   |
| <input type="checkbox"/> Anemia, excessive bleeding, bruising tendency, or bleeding disorder | <input type="checkbox"/> Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, congenital heart defects, heart murmur/rheumatic heart disease) |
| <input type="checkbox"/> Arthritic conditions  | <input type="checkbox"/> Chicken Pox  |
| <input type="checkbox"/> Artificial Bones/Joints   | <input type="checkbox"/> Colitis  |
| <input type="checkbox"/> Artificial Valves   | <input type="checkbox"/> Diabetes   |
| <input type="checkbox"/> Asthma, hay-fever, sinus trouble or hives                           |   |
| <input type="checkbox"/> Birth defects or hereditary problems                                |   |
| <input type="checkbox"/> Blood Transfusion   |   |

- Difficulty Breathing, dizziness, or easily tired
- Drug Abuse
- Emphysema
- Fainting spells epilepsy, seizures or neurological disorders
- Fever Blisters
- Frequent headaches, colds or sore throats
- Gastrointestinal Disorders
- Glaucoma
- Headaches
- Heart Surgery
- Hepatitis, jaundice or liver disorders
- Herpes
- History of eating disorder (anorexia, bulimia)
- High/Low Blood Pressure
- HIV/Aids
- Immune system disorders
- Kidney disorders
- Liver Disease

- Lupus
- Mental health disorders or depression
- Mitral Valve Prolapse
- Pacemaker
- Persistent Cough
- Pneumonia, mononucleosis, tuberculosis, polio
- Osteoporosis
- Rheumatic Fever
- Scarlet Fever
- Shingles
- Sickle Cell Disease
- Stomach ulcer or hyperacidity
- Stroke
- Thyroid or Endocrine disorders
- Tonsil or adenoid conditions
- Vision, hearing, tasting or speech difficulties
- Venereal Disease

Are there any medical conditions we have not discussed that you feel we should be aware of?

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*If the patient is taking medications, nutrient supplements, herbal medications or non prescription medications - Please list them:*

Medication: \_\_\_\_\_

Taken for: \_\_\_\_\_

*Allergies or reactions to any of the following:*

- |   |  |
|---|--|
| <input type="checkbox"/> Acrylic                    | <input type="checkbox"/> Latex (gloves, balloons) or Vinyl         |
| <input type="checkbox"/> Animals                    | <input type="checkbox"/> Local anesthetics (Novocain or Lidocaine) |
| <input type="checkbox"/> Aspirin                    | <input type="checkbox"/> Metals (jewelry, clothing snaps)          |
| <input type="checkbox"/> Barbiturates               | <input type="checkbox"/> Penicillin or other antibiotics           |
| <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Sedatives                                 |
| <input type="checkbox"/> Erythromycin               | <input type="checkbox"/> Sulfa Drugs                               |
| <input type="checkbox"/> Ibuprofen (Advil, Motrin)  | <input type="checkbox"/> Tetracycline                              |

Please list foods causing allergic reactions: \_\_\_\_\_

Please list additional drugs/materials that may cause Allergic Reactions. \_\_\_\_\_

## *Authorizations*

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_