## JEDIDIAH R. GASS, DDS, MSD, PC

Has the patient seen an ENT's cardiologist, psychiatrist, or p Does the patient have a curren Is the patient currently taking  Is the patient currently taking (examples are, but not limited Has the patient had an unusua Has the patient ever had an inju Has the patient ever had a seri Has the patient ever had any su	pecialist, endocrinological lastic surgeon? (If yes, t medical problem? any pills, medications, bisphosphonates for outo, Fosamax, Actonel, I reaction to any medical	Last Seenist, allergist, hematologicircle all that apply.)  or drugs? If yes, please steoporosis or any other	st, list.
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Has the patient ever had an injudies the patient ever had a seri	l reaction to any medica		
Has the patient ever had a seri-	with the bood took or m	ition?	
Has the patient ever had a seri	iry to the nead, race or in	outh?	
Hag the potient exerted any gu	ous illness?	10	
Thas the patient ever had any su	rgery or been hospitalize	ed?	
Has the patient had the tonsils	or adenoids removed? _	1 0	_Age
Does the patient have any cong	genital (born with) probl	lems?	
Has the patient ever been diagr	losed with a heart murm	ur?	
Is the patient allergic to anyth	ing (foods, medications	, etc.)? If yes, please list	i.
t ever been diagnosed or treated	for any of the followin	g (circle all that apply):	
Anemia	Endocrine problem	Tuberculosis	AIDS or HIV
Hepatitis	Recurrent pain	Bleeding disorder	Nervous disorde
Low/High Blood pressure	Emotional problem	Rheumatic fever	Liver problem
Communication disability	Breathing trouble	Joint replacement	Asthma
			Growth disorder
		1	Other
2		* *	
in reason for seeking orthodontic	treatment?		
_			
Is the patient currently undergo	oing any dental treatmen	t?	
Is the patient currently taking any medications for dental reasons?			
Has the patient had difficulty a	ssociated with dental tre	atment?	
Has the patient had previous o	rthodontic treatment or o	consultation?	
When?			
Has the patient had any teeth e	xtracted? Why?		
Has the patient ever injured or	broken any teeth? Expla	iin	
Does the patient have any miss	ing or extra teeth?		
Does the patient have any diffi	culty eating, speaking o	or swallowing?	
Does the patient have any habi	ts such as thumb sucking	g or nail biting?	
Does the patient have any dent	al or facial pain?		
Does the patient's jaw joint ma	ike noises or hurt?		
Has the patient's jaw ever lo	cked open or closed?		
Does the patient habitually gr	ind or clench the teeth	together?	
Does the patient normally br	eath with the lips apart	?	
Is the patient aware of any sv	vellings or growths in t	the mouth or face?	
Is the patient especially conce	erned about orthodontic	treatment?	
Is there any other medical or	dental information we	should know?	
ture (Parent or guardian if natie	nt is a minor)	D	ate
i	Is the patient ever been diagrals the patient allergic to anyth tever been diagnosed or treated Anemia Hepatitis  Low/High Blood pressure  Communication disability  Learning disability  Prolonged bleeding  Fainting/Dizziness  Is the patient currently undergoded in the patient currently taking a Has the patient had difficulty a Has the patient had previous of When?  Has the patient had any teeth exhaus the patient have any missed Does the patient have any difficulty and the patient have any dent by the patient have	Is the patient ever been diagnosed with a heart murm Is the patient allergic to anything (foods, medications to the patient allergic to anything (foods, medications). It ever been diagnosed or treated for any of the following Anemia Endocrine problem Hepatitis Recurrent pain Low/High Blood pressure Emotional problem Communication disability Breathing trouble Learning disability Heart condition Prolonged bleeding Pneumonia Bone disease DENTAL HISTORY—  Is the patient currently undergoing any dental treatment Is the patient currently taking any medications for dent. Has the patient had difficulty associated with dental tree Has the patient seen a periodontist, endodontist or oral Has the patient had previous orthodontic treatment or When?—  Has the patient had any teeth extracted? Why?—Has the patient had any teeth extracted? Why?—Has the patient have any missing or extra teeth?—Does the patient have any difficulty eating, speaking on Does the patient have any dental or facial pain?—Does the patient habitually grind or clench the teeth Does the patient habitually grind or clench the teeth Is the patient aware of any swellings or growths in Is the patient especially concerned about orthodontic Is there any other medical or dental information we ature (Parent or guardian if patient is a minor)—	Hepatitis Recurrent pain Bleeding disorder Low/High Blood pressure Emotional problem Rheumatic fever Communication disability Breathing trouble Joint replacement Learning disability Heart condition Multiple sclerosis Prolonged bleeding Pneumonia Kidney problem Fainting/Dizziness Bone disease  DENTAL HISTORY  ist Date Last Seen  iin reason for seeking orthodontic treatment?  Is the patient currently undergoing any dental treatment?  Is the patient currently taking any medications for dental reasons?  Has the patient seen a periodontist, endodontist or oral surgeon?  Has the patient had previous orthodontic treatment or consultation?



