



PAULUS ORTHODONTICS

William D. Paulus DDS, MS
Michael W. Paulus DDS, MSD

Medical History

Your current medical condition is Good Fair Poor

Are you currently under the care of a physician? _____

No Yes; please explain _____

Physicians's Name _____

Are you taking any prescription/over-the-counter drugs? _____

No Yes

Please list each one _____

Have you ever had any of the following diseases, medical problems or medical procedures?

- Y N Abnormal Bleeding
- Y N Anemia/Radiation Treatment
- Y N Artificial Bones/Joints/Valves
- Y N Asthma
- Y N Arthritis
- Y N Blood Transfusion
- Y N Cancer/Chemotherapy
- Y N Congenital Heart Defects
- Y N Diabetes
- Y N Tuberculosis
- Y N Difficulty Breathing
- Y N Drug/Alcohol Abuse
- Y N Emphysema
- Y N Glaucoma
- Y N Epilepsy/Seizures/Fainting
- Y N Fever Blisters/Herpes
- Y N Heart Murmur
- Y N Heart Surgery/Pacemaker
- Y N Hemophilia
- Y N Hepatitis
- Y N High/Low Blood Pressure
- Y N HIV+/AIDS
- Y N Hospitalization
- Y N Kidney Problems
- Y N Mitral Valve Prolapse
- Y N Psychiatric Problems
- Y N Rheumatic/Scarlet Fever
- Y N Shingles
- Y N Sinus Problems
- Y N Severe/Frequent Headaches
- Y N Heart Attack
- Y N Ulcers/Colitis
- Y N Venereal Disease

Are you pregnant? No Yes

Please list any serious medical condition(s) that you have ever had _____

Are you allergic to any of the following?

- Y N Aspirin
- Y N Erythromycin
- Y N Penicillin
- Y N Codeine
- Y N Latex
- Y N Tetracycline
- Y N Dental Anesthetics
- Y N Metals/Plastics
- Y N Other

Please list any other drugs/materials that you are allergic to: _____

I understand that the information that I have provided is correct to the best of my knowledge. I also understand that this information will be held in the 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.

Signature _____ Date _____

Reviewed _____ Date _____

About You

Name _____

Last First MI Mr Mrs Ms Dr

I prefer to be called _____ Male Female

Birth Date ____/____/____ Age _____

Home Address _____

City State Zip

Single Married Divorced Widowed Separated

Cell Phone # (____) _____

Home # (____) _____ Email _____

Work # (____) _____ Ext. _____

Occupation _____

Employer _____ How long? _____

Employer's Address _____

Where/when is the best time to reach you? _____

Other family members seen by us _____

Whom may we thank for referring you? _____

In the event of an emergency who should we contact? _____

Phone: (____) _____

Spouse/Other Information

His/Her Name _____

Employer _____

Work # (____) _____ Ext. _____

Birth Date ____/____/____

Dental History

General Dentist _____

Date of Last Exam _____

What are the main goals that you would like orthodontics to accomplish? _____

Have you ever had or been evaluated for orthodontic treatment? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Your current dental health is Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had an injury to your: mouth/teeth/chin Yes No

Do you have any missing or extra permanent teeth? Yes No

Do you generally breath through your mouth? Yes No If yes: While awake? While asleep?

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? Yes No

There's Magic in Every Smile!