Michelle Dumiller Carlton, DDS
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Denham Springs, LA 70726
225.664.9699
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Date ____________________

Patient Information

Name (last) ____________________ (first) ____________________ (middle) ____________

Name wishes to be called ____________________ Birthdate ____/____/____ Age ______ Sex M F

Address ____________________ City ____________________ St ______ Zip ______

Phone: Home ____________________ Work ____________________ Cell ____________________

Employer ____________________ Position ____________________ How Long? ______

Email ____________________ SS # ____________________

Marital Status ____________________ Spouse's Name ____________________

Please list children and ages ____________________

General Dentist ____________________ Family Physician ____________________

Whom may we thank for telling you about our office? ____________________

Appointment Confirmation

Would you like us to electronically confirm appointments by email and/or text message?

Yes: ____Email ____Text message No please call: ____ Home ____ Work ____ Cell

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Orthodontic Insurance Information

Primary policy holder's name ____________________ SS # ____________________ Birthdate ____/____/____

Primary insurance company ____________________ Address ____________________

Phone ____________________ ID # ____________________ Employer / Group # ____________________

Secondary policy holder's name ____________________ SS # ____________________ Birthdate ____/____/____

Secondary insurance company ____________________ Address ____________________

Phone ____________________ ID # ____________________ Employer / Group # ____________________

Emergency Information

Who should we contact in case of an emergency?

Name ____________________ Phone ____________________ Relationship ____________________

PLEASE COMPLETE THE BACK OF THIS FORM

Patient Health History

MEDICAL HISTORY

Yes	No	
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	Mitral valve prolapse
☐	☐	Asthma or breathing problems
☐	☐	Epilepsy or seizures
☐	☐	Hepatitis, jaundice or liver problems
☐	☐	Cleft lip/palate
☐	☐	Tonsils and/or Adenoids removed
☐	☐	Speech or hearing problems
☐	☐	Anemia or bleeding disorders
☐	☐	Sinus or allergies
☐	☐	Latex Allergy

Yes	No	
☐	☐	Heart problems
☐	☐	Heart murmur
☐	☐	High/low blood pressure
☐	☐	Kidney problems
☐	☐	Gastrointestinal disorders
☐	☐	Tuberculosis (TB)
☐	☐	Diabetes
☐	☐	Endocrine or thyroid problems
☐	☐	Bone disorders
☐	☐	Radiation treatment
☐	☐	Mental health or behavioral problems
☐	☐	HIV/AIDS
☐	☐	Sexually transmitted disease

If you have ever had any type of surgery, please describe: ______________________________

If you are allergic to any medications, please list: ______________________________

If you are taking any prescription or over-the-counter drugs, please list:

____

If you are currently under a physician's care for any medical condition, please give doctor's name and describe condition: ______________________________

Females: Is there any chance that you may be pregnant? ____ If yes, how far along? __________

DENTAL HISTORY

Yes	No	
☐	☐	Trauma to the teeth and/or face
☐	☐	Finger/thumb sucking habit
☐	☐	Cheek or lip biting
☐	☐	Clench or grind teeth
☐	☐	Mouth breather
☐	☐	Bleeding gums
☐	☐	Sensitive teeth

Yes	No	
☐	☐	Frequent cold sores
☐	☐	Periodontal disease/treatment
☐	☐	Click or pop of jaw joints
☐	☐	Jaw pain
☐	☐	Pain around the ear
☐	☐	Frequent headaches
☐	☐	Smoking

Yes	No	
☐	☐	Aware or concerned about over or under developed jaw?
☐	☐	Are there any family members with similar tooth or jaw relationship?
☐	☐	Are you concerned about the appearance of your teeth?
☐	☐	Have you ever been told that you need to take antibiotics before dental treatment?

What is your main orthodontic concern?______________________________

If you have had previous orthodontic consultation and/or treatment, please describe:

____

If there have been any injuries to the face, mouth, teeth or chin, please describe:

____

Date of last dental visit ______________ How often does the patient visit the dentist? __________

I have read and understand the above questions. The information that I have given is correct to the best of my knowledge. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history or medical/dental status I will inform this practice.

______________________________ ______________

Signature of patient Date