Welcome!

Northside Orthodontics

For your welfare and to help the doctor in his diagnosis please provide us with the following confidential information.

Christopher J. Getchell, D.D.S.

Name ____
Birth Date______________________ Age________________
Name of Physician ______________________________________

What brings you to our office today? (your main concern)________________________
____
____

How is your general health? Excellent_____ Good _____ Fair _____ Poor _____

Do you or have you had any of the following?

___ Neurological Problems
___ Psychiatric Care
___ Epilepsy/Seizures
___ Vision Problems
___ Airway Problems
___ Hay Fever, Allergies
___ Tonsil/Adenoid Problems
___ Rheumatic Fever
___ Heart Problems/Defects
___ Heart Murmurs
___ High/Low Blood Pressure

___ Thyroid Problems
___ Asthma
___ Tuberculosis
___ Respiratory Problems
___ Diabetes
___ Hepatitis or Liver Disease
___ Stomach Problems
___ Kidney Problems
___ Hormone Disorder
___ Anemia
___ Hemophilia

___ Immunilogical Disorders
___ Cancer
___ HIV / AIDS
___ Allergies/Medicines/Drugs
___ Prosthetic joint/valve
___ Osteoporosis
___ Hospitalizations (describe)
____
___ Other condition (please note)
____
____

Are you currently under medical treatment or taking any medication? _____ Yes _____ No
Please describe ____
Have you ever had any trauma to your head, neck, face, or mouth regions? _____ Yes _____ No
Please describe ____

Have you ever noticed any noises (pops, clicks, grinding) in your jaw joint area? _____ Yes _____ No
Have you ever had any pain in your jaw joint area? _____ Yes _____ No
Have you ever had an episode in which you could not open or close your jaw? _____ Yes _____ No

Approximate date of last dental visit ______________________________
Approximate date when teeth were last cleaned ________________________
Do you have any cavities or fillings that are planned for the near future? _____ Yes _____ No
Have you ever been treated for periodontal (gum) pockets or disease? _____ Yes _____ No

Are you pregnant? _____ Yes _____ No

Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?
____

Would you like to discuss a medical problem with the doctor in private? ____Yes ____No

Signature ___________________________________ Date __________________