RHONDA H. CORMNEY, D.M.D., P.S.C.
SPECIALIST IN ORTHODONTICS

Name _____ Date _____

Birthdate _____ Age _____ Social Security No. _____

Address _____

_____

Home Phone _____ Work Phone _____

Employer _____

Employer's Address _____

Occupation _____

Whom may we thank for referring you? _____

General Dentist _____ Last visit date _____

Spouse's Name _____

Employer _____

Work Phone _____ Social Security No. _____

Do you have Orthodontic Insurance _____

Insurance Co. Name _____

Address _____

Phone _____

Plan or Policy # _____

Insured's Name _____ Relationship _____

Insured's Birthday _____ SS# _____

Physician's Name _____

Physician's Phone # _____ Last visit _____

Are you currently under care of physician _____

Are you taking any medications? _____

Please List _____

Member
American Association of
Orthodontists

Have you ever had any of the following medical problems?

Y	N	Heart Murmur	Y	N	Allergies to Latex or Metal
Y	N	Rheumatic Fever	Y	N	Epilepsy/Seizures
Y	N	HIV/AIDS	Y	N	Fainting Spells
Y	N	Heart Surgery/Pacemaker	Y	N	Diabetes
Y	N	Mitral Valve Prolapse	Y	N	Hemophilia
Y	N	Artificial Valves	Y	N	Congenital Heart Defect
Y	N	High/Low Blood Pressure	Y	N	Hepatitis
Y	N	Severe/Frequent Headaches	Y	N	Blood Transfusion
Y	N	Psychiatric Problems	Y	N	Fever Blisters

Please explain any medical problems you have had:

_____

_____

List any drugs you are allergic to _____

What is your major reason for consulting an orthodontist?_____

_____

Have you ever had a problem with dental work? _____

Have you ever had any pain in your jaw joint (TMJ)? _____

Your current dental health is Good _____ Fair _____ Poor _____

Do you like your smile? _____ Do your gums ever bleed? _____

Have you ever had any injury to your mouth? _____

Do you have any missing or extra teeth? _____

I understand that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature Date