Righellis & Associates
Orthodontics for Children and Adults

Village Square at Montclair
2220 Mountain Blvd
Oakland, CA 94611
Phone: 510-482-0600
Fax: 510-482-4710

Name _____ **Date** _____

Email _____ **Update** _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Is the patient currently under medical treatment? _____ Any allergies, including nickel or latex? _____

Is the patient taking any medications? _____ If so which medications _____

Has the patient had any serious illness and/or operations? _____

Has the patient had any allergic reactions to drugs or medications? _____ If so which drugs/medications _____

Please check **yes or no** in **all** boxes below:

yes	no		yes	no		yes	no		yes	no	
○	○	ADD	○	○	AIDS/HIV	○	○	anemia	○	○	arthritis/rheumatism
○	○	artificial heart valves	○	○	asthma	○	○	bleeding problems	○	○	blood disease
○	○	bone disorders	○	○	cancer	○	○	diabetes	○	○	emotional problems
○	○	epilepsy	○	○	fainting/dizzy spells	○	○	frequent headaches	○	○	frequent colds/flu
○	○	heart problems	○	○	hepatitis-type ☐	○	○	herpes	○	○	high/low blood pressure
○	○	kidney disease	○	○	liver disease	○	○	motor difficulties	○	○	nervous problems
○	○	pneumonia	○	○	radiation treatment	○	○	sinus problems	○	○	stroke
○	○	thyroid problems	○	○	Tourette's	○	○	tonsils/adenoids . . . if removed, age _____			
○	○	tuberculosis	○	○	hayfever	○	○	other _____			

DENTAL HISTORY

Family Dentist _____ Date of last visit _____ Date of last complete full mouth x-rays _____

Please check **yes or no** in **all** boxes below:

yes	no		yes	no		yes	no	
○	○	bleeding gums	○	○	blisters on lips/mouth	○	○	prone to cavities
○	○	any missing teeth	○	○	any extra teeth	○	○	any teeth extracted
○	○	chewing difficulties	○	○	speech difficulties . . . if so explain _____			
○	○	Do you clench or grind your teeth?	○	○	Any severe head and/or facial injuries? If so explain _____			
○	○	Do you have pain or clicking upon opening/closing your mouth?				○	○	Has your jaw ever locked open or closed?
○	○	Fingernail/cheek or lip biting				○	○	History of thumb/finger biting/sucking
○	○	Do you have difficulty breathing through your nose?						
○	○	Have you ever consulted with an orthodontist? If so when _____						
○	○	Have you ever had orthodontic treatment? If so when _____						
○	○	Would you mind wearing braces to straighten your teeth?						

What about your teeth/bite would you like to correct? _____

What concerns you most about wearing braces?

☐ appearance ☐ cost ☐ length of time ☐ pain ☐ effectiveness ☐ other _____

Thank you for your cooperation.

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the Orthodontist and dental staff to perform the necessary dental/orthodontic services I may need.

Signature _____ Date _____

Clear Submit