

# GLANDER

*Orthodontics*

KARL W. GLANDER, II, D.D.S.  
KARL W. GLANDER, D.D.S., M.S.D.  
8445 South Emerson Ave, Suite 102

Indianapolis, Indiana 46227  
Phone (317) 888-2827 Fax (317) 888-2820  
www.glanderortho.com

## Patient's Family Information, Medical, & Dental History (Adult)

(please complete in ink)

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
First Last M.I. Nickname Age Sex Date of Birth

Address \_\_\_\_\_  
Street City Zip Tel. # (\_\_\_\_) \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Position \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City Zip Work Tel. # (\_\_\_\_) \_\_\_\_\_

Best telephone number to call for appointments (During Business Hours) \_\_\_\_\_

Best Fax # \_\_\_\_\_ Best Cell Phone # \_\_\_\_\_ Best E-mail Address \_\_\_\_\_

Social Security Number of Patient (for accounting purposes only) \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed  Remarried  Other

Husband/Wife Name \_\_\_\_\_  
First Last M.I. Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ (for insurance purposes only)

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Position \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City Zip Work Tel. # (\_\_\_\_) \_\_\_\_\_

Cell. # (\_\_\_\_) \_\_\_\_\_

Patient's Family Dentist \_\_\_\_\_  
Name Address Tel. #

Patient's Family Physician \_\_\_\_\_  
Name Address Tel. #

Whom may we thank for referring you to our office? \_\_\_\_\_

Do you have Orthodontic Insurance? \_\_\_\_ Yes \_\_\_\_ No Name of Insurance Company \_\_\_\_\_  
(This may be different from Dental Insurance)

Do you have Medical Insurance? \_\_\_\_ Yes \_\_\_\_ No Name of Insurance Company \_\_\_\_\_

If responsible party is other than the patient, please give information:

Not Applicable

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
(for insurance purposes only)

Address \_\_\_\_\_ Tel. # ( \_\_\_\_\_ ) \_\_\_\_\_  
Street City Zip

Does Responsible Party have Orthodontic Insurance? \_\_\_\_ Yes \_\_\_\_ No Name of Insurance Company \_\_\_\_\_  
(This may be different from Dental Insurance)

Does Responsible Party have Medical Insurance? \_\_\_\_ Yes \_\_\_\_ No Name of Insurance Company \_\_\_\_\_

### MEDICAL HISTORY

Have you had or do you have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pains	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nerve or Brain Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Migraine or Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blood Vessel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (Any type)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Any type)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Herpes (Any type)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>

Comments \_\_\_\_\_

Please list any other significant information about your medical history: \_\_\_\_\_

- Yes No
- Are you under a physician's care at present? If yes, reason \_\_\_\_\_
- Are you presently, or have you ever been, under the care of a psychiatrist or psychologist?  
If yes, describe \_\_\_\_\_
- Are you currently taking any medication? If yes, describe \_\_\_\_\_
- Are you allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, list \_\_\_\_\_
- Have you ever had any general anesthesia? When? \_\_\_\_\_
- Do you take vitamins? If yes, what type? \_\_\_\_\_
- Do you take calcium?

### FEMALE PATIENTS

- Yes No
- Have you had or has anyone in your family had osteoporosis?
- Is there a possibility that you could be pregnant?

## DENTAL HISTORY

Yes No

- Do any of your teeth hurt? If yes, upper right  upper left  lower right  lower left
- Have any wisdom teeth been removed? How many? \_\_\_\_\_
- Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe \_\_\_\_\_
- Have you ever had any previous orthodontic treatment (braces)? If yes, when \_\_\_\_\_  
If yes, doctor's name and address \_\_\_\_\_

## TMD HISTORY

Do you experience: Headaches  Ear pain  Face Pain  Other \_\_\_\_\_

How long have you had the symptoms? \_\_\_\_\_

Is the pain: Constant  Aching  Burning  Stabbing  Other \_\_\_\_\_

Worse in the morning?  Worse in the afternoon?

Do you experience: Pain in your ears  Problems with hearing  Dizziness  Ringing or buzzing in ears

Describe your problem in your own words \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes No

- Have there been any injuries to your mouth or teeth? If yes, describe \_\_\_\_\_
- Have you ever had any injury to your head or neck area? If yes, describe \_\_\_\_\_
- Have you ever fallen and bumped your chin, or received any trauma to your jaws? If yes, describe \_\_\_\_\_
- Have you ever had any surgery in the head and neck area? If yes, describe \_\_\_\_\_
- Do you clench or grind your teeth? If yes, while sleeping  under stress  other \_\_\_\_\_
- Are your teeth sore or sensitive?
- Do your jaw muscles ever feel tired? If yes, when \_\_\_\_\_
- Do you feel as though you are under a lot of stress?
- Do you ever notice soreness, tightness or pain in the muscles around the jaws or face? If yes, describe \_\_\_\_\_  
\_\_\_\_\_
- Does it hurt to chew or open wide? If yes, where does it hurt? \_\_\_\_\_
- Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:
- |                                    | Right                    | Left                     | Since when | During what activity |
|------------------------------------|--------------------------|--------------------------|------------|----------------------|
| <input type="checkbox"/> Clicking: | <input type="checkbox"/> | <input type="checkbox"/> | _____      | _____                |
| <input type="checkbox"/> Grating:  | <input type="checkbox"/> | <input type="checkbox"/> | _____      | _____                |
- Did these joint sounds begin gradually or suddenly? gradually  suddenly
- Was there some specific event that started the joint sound or pain? If yes, describe \_\_\_\_\_
- Have you ever experienced difficulty in opening or closing your jaws? If yes, describe \_\_\_\_\_
- Have your jaws ever "locked" closed? If yes, describe \_\_\_\_\_

Yes  No

Have your jaws ever "locked" wide open? If yes, describe \_\_\_\_\_

Do you have pain in your jaw joints? If yes, right  left  Since when? \_\_\_\_\_

Did your pain start gradually or suddenly?  gradually  suddenly

During what activity? \_\_\_\_\_ Describe nature of pain \_\_\_\_\_

What increases the pain? \_\_\_\_\_ What decreases the pain? \_\_\_\_\_

Do you have any of the following habits?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> Finger/Thumb sucking	<input type="checkbox"/> Lip Biting	<input type="checkbox"/> Caffeinated Beverages (coffee, soda, tea)	<input type="checkbox"/> Do you exercise regularly?
<input type="checkbox"/> Nail Biting	<input type="checkbox"/> Gum Chewing		
<input type="checkbox"/> Ice Chewing	<input type="checkbox"/> Smoke or Smokeless Tobacco User		

Please describe why you sought this consultation \_\_\_\_\_

Yes  No

Have you ever been treated for this problem before? If yes, please describe the diagnosis and treatment \_\_\_\_\_

Has any other member of the family had orthodontic treatment?

Has any other member of the family been a patient in this office?  
Name(s) \_\_\_\_\_

We recognize that patients sometimes have specific concerns that may not be addressed by the questions in this Clinical History Form. Please feel free to include any other information regarding your clinical history, or any other concerns that you may have, in the space below. If necessary, please add another sheet of paper.

\_\_\_\_\_

\_\_\_\_\_

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

(Signature of Patient) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Doctor's Signature) \_\_\_\_\_ Date \_\_\_\_\_