Thomas J. Borgula D.D.S., M.S.
Orthodontist

5805 - 24 Mile Road
Suite D
Shelby Township, Michigan 48316
Phone (586)781-2000 Fax (586)781-3540

Date

Patient Name | Birth Date | Age | Gender ☐ Male ☐ Female

Address | School | Favorite Subject

City/State | Zip Code | Hobby/Interest | Favorite Sport

Home Phone/Area Code | Mobile Phone/Area Code | E-Mail

Father's Name | Mother's Name

Have you ever taken the medication - Fosamax ☐ Yes ☐ No

Medical History

Please check to indicate if you have or have had any of the following diseases or problems.

Anemia	☐ Yes ☐ No	Liver Problems	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Smoke/Chew Tobacco	☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Persistent Cough	☐ Yes ☐ No	AIDS or HIV Infection	☐ Yes ☐ No	Ringing In The Ears	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No	Hay Fever/Seasonal	☐ Yes ☐ No	Sore Facial Muscles	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Jaw/Facial Injuries	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Mumps	☐ Yes ☐ No	Jaw Locking	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Canker Sores	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Dental/Tooth Injuries	☐ Yes ☐ No	Mental Disorders	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Clenching/Grinding Of Teeth	☐ Yes ☐ No	Bleeding Gums	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Bone Disease	☐ Yes ☐ No	Please explain:			

Do you have any disease, condition, or problem not listed above ? ☐ Yes ☐ No
Please explain:

Are you allergic to or have you had a reaction to?

Latex	☐ Yes	☐ No	☐ Don't Know	Aspirin	☐ Yes	☐ No	☐ Don't Know
Penicillin or other Antibiotics	☐ Yes	☐ No	☐ Don't Know	Sulfa Drugs	☐ Yes	☐ No	☐ Don't Know
List:				Iodine	☐ Yes	☐ No	☐ Don't Know
				Animals	☐ Yes	☐ No	☐ Don't Know
Food (Specify)	☐ Yes	☐ No	☐ Don't Know				
Metals (Specify)	☐ Yes	☐ No	☐ Don't Know				
Other (Specify)	☐ Yes	☐ No	☐ Don't Know				

Are your teeth sensitive to cold,hot, sweets or pressure ? ☐ Yes ☐ No

What Orthodontic concerns bring you to our office?

Are you taking or have you recently taken any medicine(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, what medicine(s) are you taking? Prescribed:

Over the counter:

Please Complete Both Sides

Responsible Party

Name(s)

Address *(If different than patient)

City/State * Zip Code *

Home Phone/Area Code

Employer's Name

Address

City/State Zip Code

Work Phone/Area Code

Dental Insurance Company

Contract Number/Social Security #

Group Number Birth Date

Mobile Phone/Area Code

Additional Responsible Party

Name(s)

Address *(If different than patient)

City/State * Zip Code *

Home Phone/Area Code

Employer's Name

Address

City/State Zip Code

Work Phone/Area Code

Dental Insurance Company

Contract Number/Social Security #

Group Number Birth Date

Mobile Phone/Area Code

Physician Name

Phone/Area Code

Dentist Name

Phone/Area Code

Who referred you to our office ?

NOTE: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction, I will not hold my orthodontist, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If there should be any changes in the above named patients medical or dental health it is your responsibility to update your health history information.

Signature Of Patient Legal Guardian **Date**

Authorization

By signing below you are authorizing our office to leave a Voice/Text Message or E-mail regarding the following.

Check all that apply:

- ☐ Patient Appointments
- ☐ Treatment
- ☐ Financial Information

Signature:

Print:

Date: