

Do you have a history of any serious illness, accident or operation? ()Yes ()No If yes, please give details:

Have you ever taken Fosomax or any other Bisphosphonate? () Yes () No:

Other significant physical or mental health considerations (past or present):

I have read and understand the above questions. The information provided is accurate to the best of my knowledge . I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. It is my responsibility to notify this practice if there are any changes later to this history record or medical/dental status.

Signature of patient

Date

Yes, I would like to receive email appointment reminders **Email Address**_____

Thank you for your cooperation. The above information is important in your diagnosis and treatment, and will be kept in **strict confidence**.

Office use: Medical/dental information above reviewed with patient. Initials _____ Date

Comments: _____
