

patient information

Date _____ Email Address _____

Patient's name _____

Last

First

Middle

Sex M/F

Address _____

Street

City

Zip

Birthdate _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Patient's Dentist _____ Dentist Phone _____

Who suggested that you might need orthodontic treatment? _____

Main reason for seeking orthodontic treatment _____

responsible party information

Name _____

Last

First

Middle

Residence _____

Street

City

Zip

Mailing Address _____

Street

City

Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

dental insurance information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ ID _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ ID _____

Insurance Co. Address _____ Phone No. _____

medical history

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details). Parents/Guardians please respond for minors.

Yes No Are you taking any medication/supplements/herbals? _____

Yes No Are you allergic to any medication/foods/latex/metals/acrylics/anesthetics etc? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Are you/have you taking/taken bisphosphonates for osteoporosis or other bone diseases _____

Yes No Do you chew or smoke tobacco products? If so, how long? _____

Yes No Do you have or have you ever had a substance abuse problem _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Does your physician recommend premedicating with antibiotics prior to dental procedues? _____

dental history

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you happy with the appearance of your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth or teeth? _____

- Yes No Is any part of your mouth sensitive to temperature or pressure? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Are you concerned about bad breath? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Do you have/have you had a tonsil or adenoid conditions? _____
- Yes No Have you been told you have a tongue thrust? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No What is your attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
- Yes No Are you aware of your jaw clicking or popping? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have "tension" headaches? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Are there any familial medical conditions we should know about? _____

Female Patients only:

- Yes No Are you pregnant? _____
- Yes No Has menstruation started (This is useful in monitoring/modifying growth of head and jaw bones)? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to the medical or dental history, I will so inform this practice

Signature: _____

Date: _____