



ORTHODONTICS

FOR CHILDREN AND ADULTS

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Patient Information Form

Date: _____

Personal Information

Patient's First Name: _____ **MI:** _____ **Last Name:** _____

Preferred Name: _____ **Age:** _____ **Birth Date:** _____ **Gender:** F M

Address: _____ **Phone #:** _____

School: _____ **Grade:** _____

Names & Ages of Siblings: _____

Hobbies / Interests: _____

Why are you seeking an orthodontic evaluation? _____

Has anyone in the family been treated in this office before? _____

Whom may we thank for referring you? _____

Mother's Title: Mr. Mrs. Ms. Dr. **First Name:** _____ **MI:** _____ **Last Name:** _____

Home Address: _____

Occupation: _____ **Employer:** _____

Business Address: _____

Email: _____ **Best Daytime Phone #:** _____

Father's Title: Mr. Mrs. Ms. Dr. **First Name:** _____ **MI:** _____ **Last Name:** _____

Home Address: _____

Occupation: _____ **Employer:** _____

Business Address: _____

Email: _____ **Best Daytime Phone #:** _____

If other than both parents listed above:

Name of child's legal guardian: _____

With whom does child primarily reside? _____

To whom should correspondence be addressed? _____

Medical History

Physician Name: _____ Date of last physical exam: _____

Address: _____ Phone #: _____

Patient's Height: _____ Mother's Height: _____ Father's Height: _____ Is patient adopted? _____

For the following questions, please mark Yes, No, or Don't Know. If yes, please describe. All information will be retained for our records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

	Yes	No	Don't Know
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any serious illnesses, operations, or hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medications at this time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you shown any allergies or reactions to medications, foods, or other substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol, tobacco, or controlled substances (drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Please check all that apply)

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Vision / hearing / taste / speech difficulties <input type="checkbox"/> Ear / nose / throat problems <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Fainting episodes / seizures / epilepsy <input type="checkbox"/> Hepatitis / liver / stomach / kidney problems <input type="checkbox"/> Polio / mononucleosis / tuberculosis / pneumonia <input type="checkbox"/> Asthma / bronchitis / emphysema <input type="checkbox"/> Chest pain / shortness of breath <input type="checkbox"/> Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, heart defects, heart murmur, rheumatic heart disease) <input type="checkbox"/> Hives / skin rash / skin disorder <input type="checkbox"/> Arthritis / joint / bone disorders <input type="checkbox"/> Abnormal bleeding / bruising / anemia <input type="checkbox"/> High / low blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Endocrine or thyroid problems | <ul style="list-style-type: none"> <input type="checkbox"/> Birth defects <input type="checkbox"/> Problems of the immune system / autoimmune disease <input type="checkbox"/> Mental health disturbance / depression <input type="checkbox"/> Eating disorder <input type="checkbox"/> Learning disabilities <input type="checkbox"/> Emotional disabilities <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Orthopedic total joint replacement <input type="checkbox"/> Artificial (prosthetic) heart valve <input type="checkbox"/> Previous infective endocarditis <input type="checkbox"/> Damaged valves in transplanted heart <input type="checkbox"/> Congenital heart disease (CHD) <input type="checkbox"/> Unrepaired, cyanotic CHD <input type="checkbox"/> Repaired (completely) in last 6 mos <input type="checkbox"/> Repaired CHD with residual defects <input type="checkbox"/> Use of bisphosphonates such as alendronate (Fosamax®), risedronate (Actonel®), or been treated with intravenous bisphosphonates? |
|---|---|

Has a physician or dentist recommended that you take antibiotics prior to dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any other medical conditions that we should be aware of?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Females:

Has menstruation begun?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, approximate date of first menstrual period: _____			
Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have marked Yes for any of the above, please provide details below:

Dental History

Dentist Name: _____

Address: _____ Phone #: _____

Date of last exam / cleaning: _____ Any remaining treatment required: _____

For the following questions, please mark Yes, No, or Don't Know. If yes, please describe. All information will be retained for our records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

	Yes	No	Don't Know
Did you start teething very early or very late?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you missing any teeth or have any extra teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any injury to your teeth or jaws?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any thumb / finger or pacifier sucking habit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of any clenching or grinding of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot, cold, or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed during brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a periodontal evaluation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an orthodontic evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any family history of missing or impacted teeth, or orthognathic (jaw) surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any clicking, popping, or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty opening or closing your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you breathe mostly with your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had tonsils or adenoids removed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have marked Yes for any of the above, please provide details below:

Responsible Party Information

First Name: _____ MI: _____ Last Name: _____
Birth Date: _____ SS #: _____
Billing Address: _____
Relationship to patient: _____ Best Daytime Phone #: _____

Dental Insurance Information

Subscriber First Name: _____ MI: _____ Last Name: _____
Birth Date: _____ SS #: _____
Relationship to patient: _____
Employer Name: _____ Employer Phone #: _____
Employer Address: _____
Dental Insurance Company Name: _____
Dental Insurance Company Address: _____
Dental Insurance Company Phone #: _____
Policy #: _____ Group #: _____ ID #: _____

If you have dual coverage, please provide information for the second dental insurance policy:

Subscriber First Name: _____ MI: _____ Last Name: _____
Birth Date: _____ SS #: _____
Relationship to patient: _____
Employer Name: _____ Employer Phone #: _____
Employer Address: _____
Dental Insurance Company Name: _____
Dental Insurance Company Address: _____
Dental Insurance Company Phone #: _____
Policy #: _____ Group #: _____ ID #: _____

Please bring your dental insurance card to your appointment, or provide us with a copy of the front and back of the card.

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest of confidence. **Information provided may be used to obtain credit history in order to provide the best possible payment options.**

I understand that it is my responsibility to inform this office of any changes in medical / dental status or personal information.

Signature: _____

Relationship to Patient: _____ Date: _____