PATIENT INFORMATION

Welcome to our office!

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information, which is important for our records and your health, is confidential. Thank you.

Patient's Name _____ Sex_____
FIRST MIDDLE LAST

Home Address _____ Home #_____
STREET CITY ZIP CODE

Patient's School_____ Grade_____ Age_____ Birthdate_____

Mother's Name_____ Address_____Cell #_____

Employed by_____Work #_____ E-Mail_____

Father's Name_____ Address_____ Cell #_____

Employed by_____ Work #_____ E-Mail_____

Person Responsible for Account _____Relationship_____

Insurance

Is patient covered by insurance for orthodontic treatment? (Yes/No)

Insurance Company_____Address_____

Phone_____Employer_____Group/Policy #_____

Insured Name_____SS#_____Birth Date_____Relationship_____

Name of person to be contacted if parents cannot be reached:

Name_____Phone #_____

Family History

Parent's Marital Status_____

Patient Living With: Mother Father Other:_____

Names and Ages of Brothers and Sisters_____

Father Living?_____ Health_____ Mother Living?_____ Health_____

Medical History

Height_____ Weight_____ Adopted?_____ Patient's Physician_____ Phone_____

Has the patient ever had:

Anemia	Diabetes	Hearing Disorder	HIV
Asthma	Emotional Problems	Heart Disease	Rheumatic Fever
Birth Defects	Endocrine Problems	Hepatitis	Other (describe below)
Blood Disease/Hemophelia	Epilepsy	Herpes	
Bone Disorders	Head or Face Injury	High or Low Blood Pressure	

COMMENTS:

_____

_____

Has the patient been under the care of a physician during the past two years, other than for routine examination? (Yes/No)

Condition:_____

Present drugs or medication: _____

Any allergies or reactions to any medication? _____

Has the patient reached puberty? _____

Any known allergies? (Yes/No) Specify:_____

Mouth breathing habit, snoring or difficulty in breathing? (Yes/No)

Have frequent colds, sore throat, or "stuffy nose"? (Yes/No)

Smoke (Yes/No) Any other tobacco products (Yes/No)

Has the patient received medical treatment from an allergist or ear, nose and throat specialist? (Yes/No)

Specify:_____

Dental History

Patient's Dentist_____ Date of last dental checkup_____

Were the patient's teeth cleaned?_____ Were full mouth or panoramic x-rays taken?_____

Does the patient have pain or clicking in jaw joint? (TMJ) (Yes/No)

Any tooth grinding or jaw clenching? (Yes/No)

Have any teeth been injured due to accidents or blows to the mouth? (Yes/No)

Has the patient had or been advised to have speech correction? (Yes/No)

Thumb, finger, or sucking habit? (Yes/No) Until what age?_____

Has the patient had any unusual dental experiences? (Yes/No) Specify:_____

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

Orthodontic History

Has the patient had previous orthodontic consultation or treatment? (Yes/No)

Date:_____ Dr:_____

Orthodontic consultation prompted by: Patient Dentist Mother Father

Sibling Physician Friend Other (specify):_____

Patient's interest in orthodontic treatment: Wants Treatment Treatment If Necessary Unwilling But Agrees Uncooperative

What is the primary problem?_____

Additional comments you wish to make:_____

Signature of individual completing this form:_____Date_____

Relationship to patient_____