PATIENT MEDICAL HISTORY

Physician's Name_____ Approximate date of last physical exam_____

Has patient ever been under extended care of a physician? ☐ Yes ☐ No If yes, please explain_____

_____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Anemia
☐ Asthma
☐ Cold Sores or Fever Blisters
☐ Diabetes
☐ Drug Addiction
☐ Endocrine Problems
☐ Excessive Bleeding
☐ Heart Problems
☐ Hepatitis
☐ HIV Positive (AIDS)
☐ Nervous Disorders
☐ Pain in Jaw Joints
☐ Rheumatic Fever
☐ Sinus Problems
☐ Tonsillitis
☐ Tuberculosis

Does patient gag easily?	☐ Yes	☐ No	
Does patient wear contact lenses?	☐ Yes	☐ No	
Does patient have frequent ear infections?	☐ Yes	☐ No	
Have tonsils and adenoids been removed?	☐ Yes	☐ No	At what age?_____
Women: Are you pregnant?	☐ Yes	☐ No	
Are medications now being taken ?	☐ Yes	☐ No	Please list type and reason _____

_____

Does patient have any allergies to: ☐ Yes ☐ No If yes, please list: _____

foods, medications, environmental (ie., hay fever)

_____

PATIENT DENTAL HISTORY

Dentist's Name_____ Approximate date of last dental exam _____

Have there ever been any injuries to the face, mouth, or teeth?	☐ Yes	☐ No	_____	
Has patient ever sucked their fingers or thumb?	☐ Yes	☐ No	Until what age?_____	
Does patient have any speech problems?	☐ Yes	☐ No	_____	
Is patient a mouth breather while asleep?	☐ Yes	☐ No		
Is patient a mouth breather while awake?	☐ Yes	☐ No		
Have you been informed of any extra or missing permanent teeth?	☐ Yes	☐ No	_____	
Has patient ever had a previous orthodontist exam?	☐ Yes	☐No	_____	
Have any family members had orthodontic treatment?	☐ Yes	☐ No	_____	
Is there pain in the jaw joint?	If Yes..... ☐ Right	☐ Left	When did this begin_____	
Is there any popping or cracking of the jaw joint?	If Yes..... ☐ Right	☐ Left	When did this begin_____	
Does patient clench or grind?	If Yes..... ☐ Night	☐ Day	When did this begin_____	
Does patient have headaches?	☐ Yes	☐ No		

Frequency_____ Location_____

What is the chief concern that brought you to our office?_____

_____

_____

_____

PATIENT INFORMATION

Date _____ Birthdate _____ Age _____

Patient's Name _____
Last First Middle Nickname

Address _____ Phone _____
Street City State Zip

Social Security # _____ School _____ Grade _____

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

List the names and ages of brothers and sisters _____

How did you hear about our office? _____

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

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

E-Mail Address _____ Cell Number _____

Previous Address (if less than 3 yrs) _____ Years _____
Street City State Zip at this address

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Social Security # _____ Birthdate _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

ORTHODONTIC INSURANCE INFORMATION

Primary Insured's Name _____ Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____
Street City State Zip

Insured's Employer _____ Address _____

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

Secondary Insured's Name _____ Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____
Street City State Zip

Insured's Employer _____ Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Relationship _____

Residence _____ Phone _____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor) _____

Updates (Date & Initial) _____ / _____ / _____ / _____ / _____