

Date _____

A B C

Confidential Patient Information

Patient's Name _____ Address _____

Email _____ School _____

Birthdate _____ Home 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? _____ General Dentist _____

Confidential Responsible Party Information

Name _____ Marital Status _____

Residence _____ Own Rent

Mailing Address _____ Email _____

How long at this address _____ Previous Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Year Employed _____

Name _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Year Employed _____

Insurance Information

Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group No. _____ Phone _____

Insurance Co. Address _____ Policy Holder's Employer _____

Do you have dual coverage? No Yes

Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group No. _____ Phone _____

Insurance Co. Address _____ Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Home Phone _____ Cell Phone _____ Relationship _____

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

Signature (Parent's signature if minor) _____ Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have seen a physician in the last 12 months? Why? _____

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? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about 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? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
- 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? _____
- Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Are you aware that some appointments will be during school/work hours? _____
- What is your attitude toward receiving orthodontic treatment? _____

Female Patients only:

- Yes No Are you pregnant? _____
- Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____