

Patient's name

Last

First

Middle Initial

Prefers to be called

Address _____

Street

City

Zip

Home Phone _____ Birthdate _____ Social Security # _____

Hobbies _____ Sports _____ Musical Instruments played _____

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

Attends school at _____ Grade _____

*Knowing that the American Association of Orthodontists recommends that every child age **seven** should have an orthodontic examination, is there anyone else in your family that may benefit of an orthodontic consultation?*

Name(s) _____ Age(s) _____ Relationship _____

Other family members treated here _____

Contact person in case we cannot reach you _____ Relationship _____ Phone _____

Why did you select our office? _____

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

Has anyone in your family received orthodontic treatment? _____ How did they feel about the result? _____

Do you have any concerns about orthodontic treatment? _____

Why are you seeking an orthodontic consultation? _____**Who Is Financially Responsible For This Account?**

Name _____

Last

First

Middle Initial

Address _____

Street

City

Zip

Years at this address

EMAIL Address _____ Home phone _____ Alternative Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Insurance Coverage for Orthodontic (Dental) Treatment? Yes ___ No ___Primary Policy Holder's Name (last, first, middle Initial) _____ Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

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

Secondary Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Patient Profile Is patient sensitive or self-conscious about teeth? _____

Any anxiety, conditions or disabilities that need to be taken into consideration? _____

How does patient deal with physical discomfort? _____

What is the patient's attitude toward receiving orthodontic treatment? _____

Mark Yes (Y), No (N), or Do Not Understand (dk/u)

MEDICAL HISTORY

Physician _____ City _____
Phone _____ Date of Last Visit _____

- Y__ N__ dk/u__ Birth defects or hereditary problems?
- Y__ N__ dk/u__ Bone fractures, any major accidents?
- Y__ N__ dk/u__ Rheumatoid or arthritic conditions?
- Y__ N__ dk/u__ Endocrine or thyroid problems?
- Y__ N__ dk/u__ Kidney problems?
- Y__ N__ dk/u__ Diabetes?
- Y__ N__ dk/u__ Cancer, tumor, radiation/ chemotherapy?
- Y__ N__ dk/u__ Stomach ulcer or hyperacidity?
- Y__ N__ dk/u__ Polio, mononucleosis, TB or pneumonia?
- Y__ N__ dk/u__ Immune system problems?
- Y__ N__ dk/u__ AIDS or HIV positive?
- Y__ N__ dk/u__ Hepatitis, jaundice, liver problems?
- Y__ N__ dk/u__ Neurological problems, seizures, epilepsy?
- Y__ N__ dk/u__ Mental health, behavioral problems?
- Y__ N__ dk/u__ Vision, hearing, taste, speech difficulties?
- Y__ N__ dk/u__ Loss of weight recently, poor appetite?
- Y__ N__ dk/u__ Eating disorder(bulimia/anorexia?)
- Y__ N__ dk/u__ Bleeding disorders? Anemia?
- Y__ N__ dk/u__ High or Low blood pressure?
- Y__ N__ dk/u__ Tires easily?
- Y__ N__ dk/u__ Chest pain, shortness of breath, swelling ankles?
- Y__ N__ dk/u__ Skin disorders?
- Y__ N__ dk/u__ Frequent headaches, colds or sore throats?
- Y__ N__ dk/u__ Eye, ear, nose or throat conditions?
- Y__ N__ dk/u__ Hayfever, asthma, sinus trouble or hives?
- Y__ N__ dk/u__ Tonsil or adenoid conditions?
- Y__ N__ dk/u__ Does the patient eat a well-balanced diet?
- Y__ N__ dk/u__ Cardiovascular problems (heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?)
- Y__ N__ dk/u__ have/had any history of substance abuse?
- Y__ N__ dk/u__ Chew or smoke tobacco?
- Y__ N__ dk/u__ Operations? Describe _____
- Y__ N__ dk/u__ Hospitalized? For _____
- Y__ N__ dk/u__ Other physical problems, symptoms? Describe _____
- Y__ N__ dk/u__ Being treated by another health care professional? For _____
- Y__ N__ dk/u__ Date of most recent physical exam? _____
- Y__ N__ dk/u__ Allergies or drug reactions? To _____
- Y__ N__ dk/u__ Any other medical conditions that we should be aware of? _____

DENTAL HISTORY

Dentist _____ City _____
Phone _____ Date of last visit _____

- Y__ N__ dk/u__ Started teeth very early or late? (circle either one)
- Y__ N__ dk/u__ Primary (baby) teeth removed that were not loose?
- Y__ N__ dk/u__ Presently have baby teeth?
- Y__ N__ dk/u__ Permanent or "extra" (supernumerary) teeth removed?
- Y__ N__ dk/u__ Congenitally missing teeth?
- Y__ N__ dk/u__ Chipped/ injured permanent teeth?
- Y__ N__ dk/u__ Teeth sensitive to hot, cold; throbs or ache?
- Y__ N__ dk/u__ Jaw fractures, injuries to face, cysts or mouth infections?
- Y__ N__ dk/u__ "Dead teeth" r root canals treated?
- Y__ N__ dk/u__ Bleeding gums, bad taste or mouth odor?
- Y__ N__ dk/u__ Periodontal "gum" problems?
- Y__ N__ dk/u__ Food impaction (stuck) between teeth?
- Y__ N__ dk/u__ Thumb, finger, lip sucking habit? Until what age? _____
- Y__ N__ dk/u__ Abnormal swallowing habit/ tongue thrusting?
- Y__ N__ dk/u__ History of speech problems?
- Y__ N__ dk/u__ Mouth breathing, snoring, difficulty in breathing?
- Y__ N__ dk/u__ Tooth grinding, jaw clenching, clicking or locking?
- Y__ N__ dk/u__ Any pain in jaw or ringing in the ears?
- Y__ N__ dk/u__ Difficulty in chewing or jaw opening/ closing?
- Y__ N__ dk/u__ Been treated for TMJ?
- Y__ N__ dk/u__ Any wisdom teeth problems? _____
- Y__ N__ dk/u__ Aware of loose, broken or missing fillings?
- Y__ N__ dk/u__ Any teeth irritating cheek, lip, tongue or palate?
- Y__ N__ dk/u__ Concerned about spaced, crooked or protruding teeth?
- Y__ N__ dk/u__ Aware/concerned about under or overdeveloped jaw?
- Y__ N__ dk/u__ Any relative with a similar jaw relationship? _____
- Y__ N__ dk/u__ "Gum boils", frequent canker or cold sores?
- Y__ N__ dk/u__ Taking any forms of fluoride?
- Y__ N__ dk/u__ Had periodontal (gum) treatment?
- Y__ N__ dk/u__ Any serious problems associated with previous dental treatment? _____
- Y__ N__ dk/u__ Ever had a prior orthodontic consultation or treatment?
- Y__ N__ dk/u__ Would patient object to wearing orthodontic appliances?
- Y__ N__ dk/u__ Been under another dentist/specialist care? For? _____
- Y__ N__ dk/u__ Does patient need to be **pre-medicated** prior to dental procedures? Explain _____
- How often does the patient brush? _____
- Floss? _____

FEMALE PATIENTS ONLY

- Y__ N__ dk/u__ Has the patient started her monthly periods? When? _____
- Y__ N__ dk/u__ Is the patient pregnant? (or anticipating a pregnancy?) _____

Is there additional medical/dental history information you would like us to know? _____

Are you aware that orthodontic treatment can to some extent alter facial appearance? _____

Are you aware that some appointments will be during school/working hours? _____

Are you aware that we offer flexible financial options, including treatment start without any down-payment? _____

Realizing that successful treatment greatly depends upon the patient's complete commitment and cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps or problems that we might encounter during treatment? _____

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 sometimes 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. I will not hold my orthodontist or any members of this office staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature (Parent /Legal guardian' s signature if minor) _____ **Date signed** _____

Updates/ Changes (date & initial) _____

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