WELCOME

TO OUR OFFICE

PATIENT INFORMATION

Please fill out both sides of the form.

Patient's Name______ MI____ Last______ Age____ Birthdate______ Sex___

Address______ Home Phone______

Employer/School______ Phone #______

General Dentist______ Family Physician______

Referred By______

Is patient covered by insurance for orthodontic treatment? Yes No If Yes, company name?______

Person(s) responsible for financial matter (Please list full name including middle initial)

Name(s)______ DOB______ ______ DOB______

Address______ ______

Phone work______ cell______ work______ cell______

Email______ ______

Insurance Company______ ______

Social Security #______ ______

Place of Employment______ ______

Policy/Group #______ ______

CHILDREN

Mother's Name______ Living? Yes No Occupation______

Father's Name______ Living? Yes No Occupation______

Siblings (name and age)______

Marital Status of parents______ Patient living with; Mother Father Other______

ADULTS

Marital Status______ Spouse's name______

Occupation______ Children (name and age)______

Emergency Contact______ Phone #______ Relationship______

Why did patient seek this consultation?______

What is the primary problem?______

What is expected from orthodontic treatment?______

Additional Comments______

M E D I C A L H I S T O R Y

Are you in good health? __________ Are you now under the care of a physician for a specific problem? ________

Have you ever had a serious injury or illness? _____ If yes,what was the illness or operation? ______________

Please list any allergies____

Please place an "X" if the patient has ever had:

_ Rheumatic Fever	_ Hepatitis or Liver problems	_ Tuberculosis
_ Rheumatic Heart Disease	_ Pain or Swelling in the Neck	_ Diabetes
_ Epilepsy	_ Dizzy Spells or Fainting	_ Excessive Bleeding
_ Convulsions	_ Bleeding Disorder	_ Kidney Trouble
_ Heart Trouble/ MVP	_ Nervous Condition	_ High Blood Pressure
_ Stomach Ulcers	_ Emotional Problems	_ Low Blood Pressure
_ Asthma or Hay Fever	_Arthritis	_ Frequent Headaches
_ Head or face Injury	_ Hiv pos./AIDS	_Allergies

MOUTH	RESPIRATORY	JAWS
_ Dry Mouth	_ Frequent Colds	_ Clicking or Popping
_ Gum Disease	_ Chronic Cough	_ Locking of Jaw
_ Sore Tongue	_ Stuffy Nose	_ Soreness in Jaw
_ Sensitivity	_ Frequent Sore Throat	_ Chronic Ear Ache
_ Cold Sores/Ulcers	_Frequent Swollen Tonsils	_ Chronic Headaches

Please list any medications the patient is currently taking. ______________________________

Does the patient require antibiotic premedication for teeth cleanings or other dental procedures? Yes No

Birth Defects: ______________________ Any trauma to face or head? ______________

Has the patient reached puberty? No Yes Age ______ (This information needed for growth purposes.)

Has the patient received medical treatment from allergist or ear, nose and throat specialist?

No Yes If Yes: When ______________ By Whom ______________________

Nasal Surgery ______________Tonsils Removed ______________Adenoids removed __________

P E R I O D O N T A L

Does the patient have healthy gums? Yes No If no, please explain. ______________________

Do patient's gums bleed when brushing? Yes No If no, have they ever bled? When? ______________

Does the patient floss? Yes No How often? ______________________

Has the patient had a periodontal exam? Yes No If yes,when and by whom? ______________

Has the patient been told they have a gum disease? Yes No If yes, by whom and when? __________

Has the patient ever had treatment for a gum disease? Yes No If yes, please explain. __________

Has the patient ever been told they have receding gums? Yes No If yes, please explain. __________

Will patient follow instructions regarding good oral hygiene? Yes No

Has the patient had any unusual dental experiences? ______________________________

Date of last checkup ______________ Were the patient's teeth cleaned and all dental work completed? ________

Has the patient ever been treated for T.M.J (jaw joint) problems? ______________________

Does the patient have:

Difficulty in opening?	Yes	No	Pain in jaw joint?	Yes	No
Pain in chewing or yawning?	Yes	No	Noises from the jaw?	Yes	No
Clicking in the jaw?	Yes	No	Pain when chewing?	Yes	No
Pain around the ears or cheeks?	Yes	No	Any changes in the bite?	Yes	No
A jaw that "locks"," gets stuck" or "goes out" ?				Yes	No

The following habits are of interest. List information as it pertains to patient:

Thumb/finger/lip sucking until __________(age)	Yes	No
Grinding or clenching of the teeth	Yes	No
Tongue thrusting or other functional problem	Yes	No

Has the patient ever had an orthodontic consultation ? Yes No Any type of treatment? Yes No

If yes, when? By whom?______________________________________

Signature of person completing form__________________ Relationship to patient__________Date_______