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Date ____________________

PATIENT INFORMATION

Name (last) ____________________________ **(first)** ________________________ **(middle)** ________________

Name wishes to be called ______________________ **Birthdate** _____/______ /______ **Age** _______ **Sex M F**

Address _____________________________________ **City**_________________________ **St** ______ **Zip** ________

School _______________________________ **Grade** _____ **Hobbies** ______________________________________

Please list siblings and ages____

General Dentist __________________________________ **Family Physician** ______________________________

Who is accompanying the patient today? ____

Whom may we thank for telling you about our office? ____

FAMILY INFORMATION

Mother ____

Address _____________________________________ **City**_________________________ **St** ______ **Zip** ________

Phone: Home _________________________ **Work** ________________________ **Cell** _________________________

Employer ___________________________________ **Position** _________________________ **How Long?** ________

Email ____ **SS #** ___________________ **Marital Status** _______

Father ____

Address _____________________________________ **City**_________________________ **St** ______ **Zip** ________

Phone: Home _________________________ **Work** ________________________ **Cell** _________________________

Employer ___________________________________ **Position** _________________________ **How Long?** ________

Email ____ **SS #** ___________________ **Marital Status** _______

Who will be financially responsible for the patient's treatment? ____

APPOINTMENT CONFIRMATION

Appointments should be confirmed with ____ Mother ____ Father ____ Other (__________________________)

Would you like us to electronically confirm appointments by email and/or text message?

Yes: ____Email ____Text message Cell Company (ex: AT&T, Alltel...) ______________________________

No: I would not like electronic reminders. Please call one of the following: ____Home ____Work ____Cell

ORTHODONTIC INSURANCE INFORMATION

Primary insurance company ____

Address ____ **Phone** _________________________

Policy/Group #_____________________________________**Employer** ____________________________________

Insured's Name ___________________________ **SS #** ________________________ **Birthdate** _____ /_____ /_____

Secondary insurance company ____

Address ____ **Phone** _________________________

Policy/Group #_____________________________________**Employer** ____________________________________

Insured's Name ___________________________ **SS #** ________________________ **Birthdate** _____ /_____ /_____

EMERGENCY INFORMATION

Other than parents listed above, who should we contact in case of an emergency?

Name _________________________________ **Phone**___________________ **Relationship**_____________________

PLEASE COMPLETE THE BACK OF THIS FORM

Patient Health History

MEDICAL HISTORY

Yes	No		Yes	No	
☐	☐	Rheumatic fever	☐	☐	Heart problems
☐	☐	Scarlet fever	☐	☐	Heart murmur
☐	☐	Mitral valve prolapse	☐	☐	High/low blood pressure
☐	☐	Asthma or breathing problems	☐	☐	Kidney problems
☐	☐	Epilepsy or seizures	☐	☐	Tuberculosis (TB)
☐	☐	Hepatitis, jaundice or liver problems	☐	☐	Diabetes
☐	☐	Cleft lip/palate	☐	☐	Endocrine or thyroid problems
☐	☐	Tonsils and/or Adenoids removed	☐	☐	Bone disorders
☐	☐	Speech or hearing problems	☐	☐	Radiation treatment
☐	☐	Anemia or bleeding disorders	☐	☐	Mental health or behavioral problems
☐	☐	Sinus or allergies	☐	☐	HIV/AIDS
☐	☐	Latex Allergy	☐	☐	Sexually transmitted disease

If the patient has ever had any type of surgery, please describe: ____

If the patient is allergic to any medications, please list: ____

If the patient is taking any prescription or over-the-counter drugs, please list: ______________________________

If the patient is currently under a physician's care for any medical condition, please give doctor's name and describe condition: ____

The following questions are necessary to determine your child's growth during treatment:

Patient's height _____________weight _____________ Increase in past year: height _________ weight __________

Girls: Has the patient started monthly menstrual cycle? _____ If yes, when? ________________________________

Is there any chance the patient may be pregnant? _____ If yes, how far along? ________________________

Boys: Has the patient's voice changed? ____________ If yes, when? ____

DENTAL HISTORY

Yes	No		Yes	No	
☐	☐	Trauma to the teeth and/or face	☐	☐	Frequent cold sores
☐	☐	Finger/thumb sucking habit	☐	☐	Periodontal disease/treatment
☐	☐	Cheek or lip biting	☐	☐	Click or pop of jaw joints
☐	☐	Clench or grind teeth	☐	☐	Jaw pain
☐	☐	Mouth breather	☐	☐	Pain around the ear
☐	☐	Bleeding gums	☐	☐	Frequent headaches
☐	☐	Sensitive teeth	☐	☐	Smoking

☐ ☐ Aware or concerned about over or under developed jaw?

☐ ☐ Are there any family members with similar tooth or jaw relationship?

☐ ☐ Is the patient concerned about the appearance of his/her teeth?

☐ ☐ Has patient ever been told he/she needs to take antibiotics before dental treatment?

What is your main orthodontic concern? ____

If the patient has had previous orthodontic consultation and/or treatment, please describe:

____

If there have been any injuries to the face, mouth, teeth or chin, please describe:

____

Date of last dental visit ___________________________ How often does patient visit dentist? _________________

I have read and understand the above questions. The information that I have given is correct to the best of my knowledge. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history or medical/dental status I will inform this practice.

____ _________________________________

Signature of parent or guardian Date