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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 _____ Marital Status _____
Address _____ City _____ St _____ Zip _____
Phone: Cell _____ Work _____ Email _____
Employer _____ Position _____ How Long? _____

Father _____ Marital Status _____
Address _____ City _____ St _____ Zip _____
Phone: Cell _____ Work _____ Email _____
Employer _____ Position _____ How Long? _____

Appointment Confirmation

We will electronically confirm appointments by email and text message.

Name_____ Email_____ Text_____

Name_____ Email_____ Text_____

Orthodontic Insurance Information

Primary policy holder's name _____ SS # _____ Birthdate ____/____/____
Insurance company name _____ Address _____
Phone _____ ID # _____ Employer / Group # _____

Secondary policy holder's name _____ SS # _____ Birthdate ____/____/____
Insurance company name _____ Address _____
Phone _____ ID # _____ Employer / Group # _____

Emergency Information

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	☐	☐	Gastrointestinal disorders
☐	☐	Hepatitis, jaundice or liver problems	☐	☐	Tuberculosis (TB)
☐	☐	Cleft lip/palate	☐	☐	Diabetes
☐	☐	Tonsils and/or Adenoids removed	☐	☐	Endocrine or thyroid problems
☐	☐	Speech or hearing problems	☐	☐	Bone disorders
☐	☐	Anemia or bleeding disorders	☐	☐	Radiation treatment
☐	☐	Sinus or allergies	☐	☐	Mental health or behavioral problems
☐	☐	Latex Allergy	☐	☐	HIV/AIDS
			☐	☐	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 potential during treatment:

Girls: Has the patient started monthly menstrual cycle? _____ If yes, date of first cycle? _____

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 their teeth?

☐ ☐ Has the patient ever been told that they need 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 the patient visit the 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/Guardian Date