

PATIENT MEDICAL HISTORY

Physician's Name _____ Approximate date of last physical exam _____

Has patient ever been under extended care of a physician? Yes No If yes, please explain _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cold Sores or Fever Blisters | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive (AIDS) | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Endocrine Problems | | |

- Does patient gag easily? Yes No
- Does patient wear contact lenses? Yes No
- Does patient have frequent ear infections? Yes No
- Have tonsils and adenoids been removed? Yes No At what age? _____
- Women: Are you pregnant? Yes No
- Are medications now being taken? Yes No Please list type and reason _____

Does patient have any allergies to: Yes No If yes, please list: _____
foods, medications, environmental (ie., hay fever)

PATIENT DENTAL HISTORY

Dentist's Name _____ Approximate date of last dental exam _____

- Have there ever been any injuries to the face, mouth, or teeth? Yes No _____
- Has patient ever sucked their fingers or thumb? Yes No Until what age? _____
- Does patient have any speech problems? Yes No _____
- Is patient a mouth breather while asleep? Yes No
- Is patient a mouth breather while awake? Yes No
- Have you been informed of any extra or missing permanent teeth? Yes No _____
- Has patient ever had a previous orthodontist exam? Yes No _____
- Have any family members had orthodontic treatment? Yes No _____
- Is there pain in the jaw joint? If Yes..... Right Left When did this begin _____
- Is there any popping or cracking of the jaw joint? If Yes..... Right Left When did this begin _____
- Does patient clench or grind? If Yes..... Night Day When did this begin _____
- Does patient have headaches? Yes No

Frequency _____ Location _____

What is the chief concern that brought you to our office? _____

PATIENT INFORMATION

Date _____ Birthdate _____ Age _____

Patient's Name _____
Last First Middle NicknameAddress _____ Phone _____
Street City State Zip

Social Security # _____ School _____ Grade _____

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

List the names and ages of brothers and sisters or siblings _____

How did you hear about our office? _____

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

RESPONSIBLE PARTY INFORMATIONName _____ Marital Status _____
Last First MiddleResidence _____
Street City State ZipMailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

E-Mail Address _____ Cell Number _____

Previous Address (if less than 3 yrs) _____ Years _____
Street City State Zip at this address

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Social Security # _____ Birthdate _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

ORTHODONTIC INSURANCE INFORMATION

Primary Insured's Name _____ Social Security # _____

Mailing Address _____ Date of Birth _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____
Street City State Zip

Insured's Employer _____ Address _____

Do you have dual coverage? Yes No If yes:

Secondary Insured's Name _____ Social Security # _____

Mailing Address _____ Date of Birth _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____
Street City State Zip

Insured's Employer _____ Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Relationship _____

Residence _____ Phone _____
Street City State Zip

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

Signature (Parents signature if minor) _____

Updates (Date & Initial) _____ / _____ / _____ / _____ / _____