

**PATIENT INFORMATION**

Date \_\_\_\_\_ Chart # \_\_\_\_\_

Name \_\_\_\_\_  
Last First Initial Preferred Name

Address \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Phone \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

What is the reason for seeking orthodontic treatment? \_\_\_\_\_

\_\_\_\_\_

Have you seen other orthodontists concerning the problem in the past? Yes  No

Does anyone in your family have a similar dental problem? Yes  No

Has anyone in your family had orthodontic treatment? Yes  No

Whom may we thank for referring you to our office? \_\_\_\_\_

Please list any special interests (sports, hobbies, pastimes, etc.) \_\_\_\_\_

\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Father's Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Yrs \_\_\_\_\_

Mother's Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Yrs \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Billing Address if different from above \_\_\_\_\_

**Preferred Method of Contact:**  Phone \_\_\_\_\_  E Mail \_\_\_\_\_

Patient lives with:  both parents  mother  father  other

Number of brothers \_\_\_ ages ( ) ( ) ( ) Number of sisters \_\_\_ ages ( ) ( ) ( )

**DENTAL INSURANCE INFORMATION**

Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Phone No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes:

Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Phone No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

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

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & Initial) \_\_\_\_\_

## MEDICAL HISTORY

Date of last physical examination \_\_\_\_\_

Is the patient currently under the care of a physician? \_\_\_\_\_ If so, why? \_\_\_\_\_

Is the patient taking any medication now? \_\_\_\_\_ If so, for what? \_\_\_\_\_

Has the patient ever been treated for any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV +	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>				Depression	<input type="checkbox"/>	<input type="checkbox"/>

Does the patient often have colds , sore throats , or ear infections ?

Yes No

Does the patient have any difficulty in breathing through his/her nose? .....

Have the tonsils and adenoids been removed? at what age? .....

Please list any allergies and/or drug sensitivities \_\_\_\_\_

Please describe any present or past medical problems, hospitalizations or operations:

Does the patient have any special problems that have not been mentioned above? \_\_\_\_\_

## DENTAL HISTORY

Yes No

When did the patient last visit his/her dentist? \_\_\_\_\_ were x-rays taken? .....

Have there been any injuries to the face, mouth, or teeth? .....

Please explain \_\_\_\_\_

Yes No

Has the patient had any teeth (baby or permanent) removed by a dentist? .....

Did the patient ever suck his/her thumb? .....

If yes, to what age? \_\_\_\_\_

Does the patient have any of the following habits? lip biting  pencil biting  .....

finger nail biting  Other \_\_\_\_\_

1. Has the patient had speech  or tongue thrust  therapy? .....

2. Does the patient have any speech problems at the present time? .....

3. Are the patient's teeth or gums sensitive? .....

4. Do his/her gums bleed easily? .....

5. Does the patient have pain or difficulty when chewing, talking, or using his/her jaw? .....

6. Does the patient have pain in or about the jaws, ears, temples, or cheeks? .....

7. Does the patient have frequent headaches? (more than 1 per week)? .....

8. Does the patient's jaw "catch or lock" when opening wide, for instance yawning? .....

9. Is the patient aware of noises in his/her jaw joints? .....

10. Has the patient's bite felt uncomfortable or unusual? .....

11. Are you aware of the patient clenching or grinding during the day or night? .....

12. Has the patient been previously treated for a jaw joint problem? .....

If so when? \_\_\_\_\_

13. Does the patient have arthritis? .....

14. Has the patient had a recent injury to his/her jaw, head or neck? .....