ORTHODONTIC PATIENT INFORMATION

Confidential Patient Information

Patient's Name _____
Last First Middle Initial

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ School _____ Grade _____

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

Siblings (name and age) or Children _____

Family Dentist Name _____ Phone Number _____

Address _____
Street City State Zip

Family Physician/Pediatrician Name _____ Phone Number _____

Address _____
Street City State Zip

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

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle Initial

Residence _____
Street City State Zip

Mailing Address (if different from above) _____
Street / P.O. Box City State Zip

How long at current address? _____ Previous Address (if less than 3 years) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Social Security Number _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Number Years Employed _____

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

Employer _____ Occupation _____ Number Years Employed _____

Social Security Number _____ Birthdate _____ Work Phone _____ Cell Phone _____

Orthodontic Insurance Information

Primary Policy Holder's Name _____ Birthdate _____ SSN/Member Number _____

Name of Insurance Company _____ Group Number _____ Ins. Phone Number _____

Primary Policy Holder's Employer _____ Do you have dual coverage? No Yes

Secondary Policy Holder's Name _____ Birthdate _____ SSN/Member Number _____

Name of Insurance Company _____ Group Number _____ Ins. Phone Number _____

Secondary Policy Holder's Employer _____

(Please note: we only submit to your primary dental insurance company, but we will supply you with all forms needed for you to submit to your secondary policy.)

Emergency Contact Information

Name of nearest relative not living with you _____

Complete address _____

Phone number _____ Relationship _____

Has the patient been under the care of a physician during the past two years, other than for routine examinations? Yes No

Condition: _____

Does the patient require pre-medication for dental procedures? Yes No Have any birth defects? _____

Has the patient reached puberty (i.e., menstruation, hair)? Yes No If "Yes", at what age? _____
(This information is needed for growth purposes.)

Respiratory History Does the patient:

1. Have allergies to: Seasonal grasses _____ Food _____
   Drugs _____ Other _____
2. Snore when sleeping? Yes No
3. Have frequent "stuffy nose"? Yes No
4. Have frequent sore throat or tonsillitis? Yes No
5. Have chewing or swallowing difficulty? Yes No
6. Breathe through his/her mouth? Usually Sometimes Seldom

Has the patient received medical treatment from an allergist or from an ear, nose & throat specialist? Yes No

If "Yes": When _____ By Whom _____

Has the patient ever had: Nasal Surgery _____ Tonsils Removed _____ Adenoids Removed _____

Medical History Has the patient ever had:

Allergy	Cold Sores	Headache/Migraine	Kidney Disease
Anemia	Diabetes	Heart Condition	Oral Ulcer
Arthritis	Endocrine Problems	Head or Face Injury	Previous Surgery
Asthma	Emotional Problems	Hepatitis	Rheumatic Fever
Bleeding	Epilepsy/Seizures	Herpes	Thyroid Problems
Cancer	Hearing Problems	HIV problems	Other (please describe)

Comments: _____

Dental and Temporomandibular Joint History

Has the patient had any unusual dental experiences? Yes No

If "Yes", please explain: _____

Date of patient's last dental checkup: _____ With Dr.: _____

Were the patient's teeth cleaned? Yes No

Does the patient have:

1. Difficulty in mouth opening? Yes No
2. Pain or clicking in jaw joint? Yes No
3. Pain while chewing, yawning or opening wide? Yes No
4. Pain in or about the ears or cheeks? Yes No
5. A bite that feels uncomfortable or "unusual"? Yes No
6. A jaw that "locks", gets "stuck" or "goes out"? Yes No
7. Noises in or from the jaw joints? Yes No

Has the patient ever been treated for T.M.J. (jaw joint) problems? Yes No

Has the patient had habits of:

1. Thumb/finger/lip sucking until _____age? Yes No
2. Grinding or clenching of the teeth? Yes No
3. Tongue thrusting or other functional problem? Yes No
4. Musical instrument played _____ Yes No

Has the patient had a previous orthodontic consultation? Yes No

If "Yes", with Dr.: _____ Date: _____

Has the patient had any previous orthodontic treatment? Yes No

If "Yes", with Dr.: _____ Date: _____

Please explain yours or the dentist's chief concern and reason for seeking this consultation: _____

_____

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

Signature (Parent's Signature if patient is a minor) _____ Date _____