Date: _____

Confidential Patient Information

Patient Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Date of Birth _____ Social Security # _____ - _____ - _____

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

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

Confidential Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) Marital Status _____

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

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

Previous Address (if less than 3 yrs) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ - _____ - _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ - _____ - _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ Soc. Sec. or ID # _____ - _____ - _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name _____ Soc. Sec. or ID # _____ - _____ - _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

For the following questions check **yes** or **no**. The answers are for office records only and will be considered confidential.
A complete history is vital to proper orthodontic evaluation. For any questions answered "yes" please give details below.

MEDICAL HISTORY

☐yes ☐no Birth defects or hereditary problems?
☐yes ☐no Bone fractures, any major accidents?
☐yes ☐no Rheumatoid or arthritic conditions?
☐yes ☐no Endocrine or thyroid problems?
☐yes ☐no Kidney problems?
☐yes ☐no Diabetes?
☐yes ☐no Cancer or treatment for tumor?
☐yes ☐no Fainting spells, seizures, epilepsy?
☐yes ☐no Mental health or behavioral problems?
☐yes ☐no Mental health or behavioral problems?
☐yes ☐no Vision, hearing, taste or speech difficulties?
☐yes ☐no Loss of weight or poor appetite?
☐yes ☐no High or low blood pressure?
☐yes ☐no Excessive bleeding, anemia or other bleeding disorders?
☐yes ☐no Easily tired?
☐yes ☐no Chest pain, shortness of breath, ankle swelling?
☐yes ☐no Cardiovascular problems (heart trouble, heart attack, coronary Insufficiency, arteriosclerosis, stroke, inborn heart disease, Or history or rheumatic fever or rheumatic heart)?
☐yes ☐no Skin disorder?
☐yes ☐no Do you have a normal and balanced diet?
☐yes ☐no Frequent headaches, colds, sore throats?

☐yes ☐no Any history of speech problems?
☐yes ☐no Eye, ear, nose, throat conditions?

☐yes ☐no Received trauma (teeth, face, jaws or head)?
☐yes ☐no Hayfever, asthma, sinus trouble, hives?
☐yes ☐no Polio, mononucleosis, tuberculosis or pneumonia?
☐yes ☐no Problems of the immune system?
☐yes ☐no Hepatitis, jaundice or liver problem?
☐yes ☐no AIDS or HIV positive?
☐yes ☐no Sexually transmitted disease?
☐yes ☐no Are you taking medications, nutrition supplements, or non-prescription medicine? Please name them:
_____

☐yes ☐no Have you ever had a substance abuse problem?
☐yes ☐no Do you use tobacco products?
☐yes ☐no Other physical problems or symptoms?
☐yes ☐no Allergy to metals?
☐yes ☐no Allergy to latex or rubber?
☐yes ☐no Allergies or drug reactions: _____
☐yes ☐no Being treated by another health care professional?
For: _____

☐yes ☐no Are you in good health?
Date of most recent physical exam: _____

Female Patients:
☐yes ☐no Are you pregnant?
☐yes ☐no Are you taking birth control pills?

DENTAL HISTORY

☐yes ☐no Chipped or otherwise injured permanent teeth?
☐yes ☐no Teeth sensitive to hot or cold, teeth throb or ache?
☐yes ☐no Jaw fractures, cysts, mouth infections?
☐yes ☐no "Dead teeth", root canal therapy?
☐yes ☐no Bleeding gums, bad taste or odor in mouth?
☐yes ☐no Periodontal or "gum" problems?
☐yes ☐no Food impaction between teeth?
☐yes ☐no "Gum boils", canker sores, cold sores?
☐yes ☐no Thumb or finger sucking habits? Till age: _____
☐yes ☐no Abnormal swallowing habit (tongue thrust)?
☐yes ☐no Mouth breathing, snoring, difficulty breathing?
☐yes ☐no Tooth grinding, or clenching?
☐yes ☐no Clicking, popping, grating or grinding sounds in jaw joints?
☐yes ☐no Have you ever experienced any pain or soreness in the muscles of your face or around the ears?
☐yes ☐no Any pain in jaw or ringing in the ears?
☐yes ☐no Have you ever been treated for "TMJ" problems?
☐yes ☐no Difficulty encountered in chewing or jaw opening?
☐yes ☐no Has your jaw ever locked open or closed?
☐yes ☐no History of extra or congenitally missing teeth?

☐yes ☐no Have any permanent teeth been removed?
☐yes ☐no Any loose or broken fillings or restorations?
☐yes ☐no Any irritation of cheek, lip, tongue or palate?
☐yes ☐no Have you ever had periodontal (gum) treatment?
☐yes ☐no Any relatives with similar tooth or jaw relationships?
☐yes ☐no Any wisdom tooth problems?

What are your main concerns regarding the jaw and teeth?
☐Crowding ☐Over-bite ☐"Buck" teeth ☐Receded jaw ☐Prominent jaw
☐Gummy smile ☐Spaces ☐Gum disease/recession ☐Missing teeth
☐Jaw dysfunction ☐Mouth too small ☐Irregular facial proportions
☐Irregularly shaped teeth ☐Protrusion of teeth ☐Ringing/stiffness of ears
☐Headaches/facial pain ☐Neck pain ☐Jaw pain ☐Clicking jaw joint
☐Other

Who was orthodontic consultation prompted by?
☐Patient ☐Dentist ☐Mother ☐Father ☐Spouse ☐Sibling ☐Physician
☐Friend ☐Other

Why are you seeking this consultation?
☐To correct overbite ☐To eliminate crowding ☐To eliminate facial pain
☐To correct jaw dysfunction problems ☐To improve general appearance
☐To improve facial proportions ☐To close spaces ☐Other

For any questions answered "yes" or "other" above, please detail: _____

_____

I have read and understand the above questions. I will not hold my orthodontist(s) or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes in my medical or dental history I will inform this practice immediately.

_____ _____ _____
Privacy Policy Responsible Party Signature Date

MEDICAL/DENTAL HISTORY UPDATES OR CHANGES

Date Update or Changes Comments Responsible Party Signature

_____

_____