Specialists in Orthodontics

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Patient Information

Date ______________________

Patient's Name ______________________ Last ______________________ First ______________________ Middle

Address ______________________ Street ______________________ City ______________________ State ______________________ Zip

Home Phone ______________________ Birthdate ______________________ Social Security # ______________________

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

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

Responsible Party Information

Name ______________________ Last ______________________ First ______________________ Middle ______________________ Maiden Name

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 ______________________ Last ______________________ First ______________________ Middle ______________________ Relationship to Patient ______________________

Employer ______________________ Occupation ______________________ No.Years Employed ______

Social Security # ______________________ Birthdate ______________________ Work Phone ______________________

Insurance Information

Insured's Name ______________________ Insured's Soc. Sec. # ______________________

Insurance Company ______________________ Group No. ______________________ Local No. ______________________

Insurance Co. Address ______________________

Do you have dual coverage? Yes No If yes:

Insured's Name ______________________ Insured's Soc. Sec. # ______________________

Insurance Co. ______________________ Group No. ______________________ Local No. ______________________

Insurance Co. Address ______________________

Insured's Employer ______________________

Emergency Information

Name of nearest relative not living with you ______________________

Complete Address ______________________

Phone ______________________

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

Signature (Parent's signature if minor) ______________________

Updates (date & initial) ____________ ____________ ____________ ____________ ____________

Confidential (for record and pretreatment evaluation)

Name of your regular dentist____

Address____Telephone____________________

Name of your regular physician____

Address____Telephone____________________

MEDICAL HISTORY OF PATIENT

Please circle any condition for which the patient has been diagnosed or treated:

Heart Problems
Circulatory Problems
Rheumatic Fever
Asthma
Pneumonia
Nervous Disorders
Psychological Problems
Dizziness/Fainting
Tuberculosis
High Blood Pressure

Epilepsy
Anemia
Prolonged Bleeding
Kidney Problems
Tumors/Neoplasms
Bone Disorders
Multiple Bone Fractures
Liver Disorders
Endocrine Disorders
Temporomandibular Problems

Gout
Sinus/Ear Infections
Frequent Colds
Eating Disorders
Frequent Sore Throats
Arthritis
Diabetes
Digestive Disorders
Glaucoma

Are there allergies to any medications? Yes No
If yes, which?____

____

Are medications now being taken? Yes No
If yes, which?____

____

Is patient presently under physician's care? Yes No

Has the patient had any severe childhood diseases? Yes No
If yes, which?____

____

If female, has menses occurred? Yes No
are you pregnant? Yes No

Have you been diagnosed (yes - no) or are you at risk (yes - no) for hepatitis, herpes, or A.I.D.S.?

Have you been diagnosed or treated for any medical or surgical conditions not mentioned above? Yes No
If yes, which?____

____

DENTAL HISTORY OF PATIENT

Has a dentist mentioned any unusual dental condition? Yes No
If yes, which?____

____

Have there been many cavities in the past? Yes No

Have there been any injuries to the teeth? Yes No
If yes, what and when?____

____

Did any teeth abcess or have gum boils? Yes No

Were any teeth removed by extraction? Yes No
If yes, was it suggested that the space be maintained? Yes No
If yes, was an appliance placed? Yes No

Does the patient breathe through the mouth or are the lips parted?

Have there been any habits which might have caused the teeth to move; such as, lip or nail biting, thumb sucking, etc.? Yes No

Are there any speech problems? Yes No

Has there been an unfavorable experience in a dental office? Yes No
If yes, please explain ____________________

____

Has an orthodontist been consulted previously? Yes No
If yes, are you requesting a second opinion? Yes No

When was the last dental care? ____________________

When were the last dental x-rays taken?____________________

By whom?____________________

Has there been any experience with noise (clicking, popping, or grating) and/or discomfort in front of the ear(s) when the lower jaw moves? Yes No
If yes, please explain____________________

____

____

What do you believe is your orthodontic problem and what would you most like orthodontic treatment to accomplish?

____

____

____

Remarks:____________________

____

____

____

I UNDERSTAND THAT IF DIAGNOSTIC RECORDS (THAT IS: CASTS, X-RAYS, PHOTOS) ARE TAKEN THERE IS A CHARGE FOR THESE RECORDS.

RESPONSIBLE PARTY SIGNATURE____________________ **DATE**____________________